4 1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14212 — 14236

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

80 22 1

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First / Middle / Last | Percy . ACKERMAN | 2a. DATE OF DEATH Month / Day / Year | September 11 70 |
| 2b. HOUR | 6A M | | |
| 3. SEX | Female | 4. RACE | White |
| 5. DATE OF BIRTH | Dec 31, 1893 | 6. AGE (In years last birthday) YRS. | 77 |
| IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | New Jersey | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | 9. COUNTY OF DEATH | Wicomico Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hospital |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Retired Farmer | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | 13b. COUNTY | Wicomico |
| 13c. CITY OR TOWN | Delmar | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | |
| 13e. STREET AND NUMBER | R.F.D. 3 | | |
| 14. FATHER'S NAME First / Middle / Last | Richard B. Ackerman | 15. MOTHER'S MAIDEN NAME First / Middle / Last | Rachel Zabriski |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | |
| 17. INFORMANT Address | Mrs Mildred B. Ackerman Delmar Md. | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Artery Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) & Congestive failure — 15 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 8/27, 19 70, to Sept. 11, 19 70, that (I) (we) last saw the deceased alive on Sept. 10 19 70, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: David F. Gilmore M.D. DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type) — 22e. ADDRESS

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | Burial | 23b. DATE | 9/15/70 | 23c. NAME OF CEMETERY OR CREMATORY | Vallean Cemetery |
| 23d. LOCATION (City or Town) (County) (State) | Riderwood Md. | | | | |
| 24. FUNERAL DIRECTOR | Levin R. Weber | ADDRESS | Princess Anne Md. | 25a. REC'D BY REGISTRAR DATE | SEP 16 1970 |
| 25b. REGISTRAR'S SIGNATURE | J. Charles Judge | | | | |

VR A15 (4)
45M - 1/69

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14213

Item#6, Film G42S 10/2/70 km

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14237

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| ANNIE | M. (Davis) | ADKINS | September 21 1970 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | November 1, 1874 | 96/95 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | John B. Parsons Home | Housewife | ---- |

| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES ☐ NO ☐ | Lake Street |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| T. | James | Davis | Mary | E. | Godfrey |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| No | | | Records of John B. Parsons Home, Salisbury, Md |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiovascular renal disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4044

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from July, 1963, to Sept 21, 1970, that (I) (we) last saw the deceased alive an May 1970, and that in (my) (our) apinian death occurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Philip A. Insley | | ☒ | ☐ | ☐ | September 21 /1970 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Dr. Philip A. Insley | Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 23, 1970 | Parsons Cemetery | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | SEP 24 1970 | J. Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

14214

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14238

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form MM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: MAXWELL | Middle: J. | Last: ANDERSON | 2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Day Year: 9-22-70 | 2b. HOUR: 5A M | |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH: 9-19-1895 | 6. AGE (In years last birthday): 75 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month 9 Day 22 Year 70 | 2d. HOUR: M | |
| 7a. BIRTHPLACE (State or foreign country): Md. | 7b. CITIZEN OF WHAT COUNTRY?: U.S. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Armour & Meat Co. | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Baltimore | 13c. CITY OR TOWN: Baltimore | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET AND NUMBER: 1005 Beach Field Ave. | | |
| 14. FATHER'S NAME First: Ester | Middle: | Last: Anderson | 15. MOTHER'S MAIDEN NAME First: Sonja | Middle: | Last: Haxman | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes | (If yes give war or dates of service): WW I | 16b. SOCIAL SECURITY NO.: 212-05-9196 | 17. INFORMANT: Mrs Girlon Anderson | ADDRESS: Baltimore Md. | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4/23

(b): Arteriosclerotic heart disease — years

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md

22b. DATE SIGNED: Sept. 22, 1970

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9/25/70 | 23c. NAME OF CEMETERY OR CREMATORY: Louden Park Cem. | 23d. LOCATION (City or Town) (County) (State): Baltimore, Md. | |
| 24. FUNERAL DIRECTOR: Messick Funeral Home, Bivalve, Md. | ADDRESS | 25a. REC'D BY REGISTRAR DATE: SEP 29 1970 | 25b. REGISTRAR'S SIGNATURE: J. Charles Judge | |

VR A15ME (5) 10M - 1/69

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14215

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14239

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: ETHEL | Middle: | Last: Atkinson | 2a. DATE OF DEATH Month: September | Day: 20 | Year: 70 |
| 2b. HOUR: 9:20 M | | | | | |
| 3. SEX: Female | 4. RACE: white | 5. DATE OF BIRTH: January 11, 1882 | 6. AGE (In years last birthday): 88 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): England | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico | | Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: own home | | |
| 13a. USUAL RESIDENCE (Where deceased lived before admission) STATE: Maryland | 13b. COUNTY: Montgomery | 13c. CITY OR TOWN: Takoma Park | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 8604 Flower Ave., Tk. Pk., | |
| 14. FATHER'S NAME First: William | Middle: | Last: Crompton | 15. MOTHER'S MAIDEN NAME First: Sara | Middle: | Last: Kimer |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: yes | 17. INFORMANT Address: Ethel Adams, 8604 Flower Ave., Tk. Pk., Md. | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Rupture Suspected
DUE TO, OR AS A CONSEQUENCE OF (b): Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (c): A.S.C.V.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 hours

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (~~this hospital~~) attended the deceased from 9-20, 1970, to 9-20, 1970, that (I) (~~we~~) last saw the deceased alive an 9-20 1970, and that in (my) (~~our~~) apinian death accurred an the date and haur and fram the causes stated abave, (I) (~~we~~) (did) (~~did not~~) view the bady after death.

22b. SIGNATURE: Joseph C. Fitzgerald M.D. DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22c. DATE SIGNED: 9/20/70

22d. PHYSICIAN'S NAME (Type): Joseph C. Fitzgerald, Md. 22e. ADDRESS: Salisbury, Md.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Cremation | Sept. 24, 1970 | Fort Lincoln Crematory | Bladensburg Prince Geo. MD |

24. FUNERAL DIRECTOR: Carter C. Allen Carter ADDRESS: Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md.

25a. REC'D BY REGISTRAR DATE: SEP 24 1970 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 45M - 1/69

1702

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14216

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14240

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: THOMAS | Middle: S | Last: Aydelotte | 2a. DATE OF DEATH Month: September | Day: 12 | Year: 1970 |
| 2b. HOUR: 9:50 A M | | | | | | |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH: SEPT. 7, 1904 | 6. AGE (In years last birthday): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Worker | 12b. KIND OF BUSINESS OR INDUSTRY: ICE PLANT | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: WOR. | 13c. CITY OR TOWN: OCEAN CITY | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 406 14th St. | | |
| 14. FATHER'S NAME First: THOMAS | Middle: S. | Last: AYDELOTTE | 15. MOTHER'S MAIDEN NAME First: HATTIE | Middle: | Last: FREEMAN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No | 16b. SOCIAL SECURITY NO.: No | 17. INFORMANT: Mrs. T.S. Aydelotte | Address: Ocean City MD | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancerous Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
1621
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town / County / State |

22a. **I certify** that (I) (this hospital) attended the deceased from 9-4, 19 70, to 9-12, 19 70, that (I) (we) last saw the deceased alive on 9-11 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Louis W. Cave Jr. — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type) — 22e. ADDRESS

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 9/15/70 | 23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN | 23d. LOCATION (City or Town): BERLIN | (County): WOR. (State): MD |
| 24. FUNERAL DIRECTOR: Anna D. Burbage | ADDRESS: Berlin Md | 25a. REC'D BY REGISTRAR DATE: SEP 18 1970 | 25b. REGISTRAR'S SIGNATURE: J. Charles Judge | |

VR A15 (4)
45M - 1/69

14217

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14241

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| CHARLES | GLADSTONE | BALL | September | 28 | 1970 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | November 24, 1897 | 72 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Salisbury Nursing Home | Farmer | Farming |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Eden | YES ☐ NO ☐ | Rt. 1 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Charles | Christopher | Ball | Bertha | | Brewington |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Wife) Address | |
|---|---|---|---|
| No | 219-34-4059 | Mrs. Mattie Ball, Eden, Maryland | Rt. 1 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of bladder with

DUE TO, OR AS A CONSEQUENCE OF (b) Widespread metastasis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

188X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 4/15, 1970 to 9/28, 1970, that (I) (we) last saw the deceased alive on 9/26 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE Dr. E. M. Beardsley DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED September 28/1970

22d. PHYSICIAN'S NAME (Type) Dr. E. M. Beardsley

22e. ADDRESS Salisbury, Maryland

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | September 30, 1970 | Zion Cemetery | R.D., Salisbury, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | OCT 2 1970 | J. Charles Judge |

VR A15 (4) 30M REV. 1/68

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

3 12 14218 — 14242

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Katie | Middle: M | Last: BARKLEY | 2a. DATE OF DEATH Month: SEPTEMBER Day: 2 Year: 1970 | 2b. HOUR: 12 P.M | |
| 3. SEX: Female | 4. RACE: Col | 5. DATE OF BIRTH: Jan 17 1900 | 6. AGE (In years last birthday): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): Worcester | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer | 12b. KIND OF BUSINESS OR INDUSTRY: None | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: Woodlyn Dr. | | |
| 14. FATHER'S NAME First: unk | Middle | Last | 15. MOTHER'S MAIDEN NAME First: unk | Middle | Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 218-24-4452 | 17. INFORMANT: Mable Barkley | Address | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Pulmonary Emboli, massive — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 min
592 X
DUE TO, OR AS A CONSEQUENCE OF
(b): acute anterior-lateral myocardial infarct - wk.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. and
DUE TO, OR AS A CONSEQUENCE OF
(c): Post-operative Right nephrectomy — 9 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Cerebral emboli - 3 days duration

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: 24 Aug 70 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Staghorn Calculus (R) | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote | |

22a. **I certify** that ~~I~~ (this hospital) attended the deceased from 17 Aug, 1970, to 2 Sept, 1970, that ~~I~~ (we) last saw the deceased alive an 2 Sept 1970 and that in ~~my~~ (our) apinian death accurred on the date and haur and fram the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the bady after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Wm O Bruce MD DEGREE | ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ | 22c. DATE SIGNED: 3 Sept 70 | |
| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS | | |

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9-6-70 | 23c. NAME OF CEMETERY OR CREMATORY: Sprong Hill Mem | 23d. LOCATION (City or Town): Salisbury | (County): Wico | (State): Md |
| 24. FUNERAL DIRECTOR: Bookert Dept | ADDRESS | 25a. RECD BY REGISTRAR DATE: SEP 8 1970 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | | |

VR A15 (4)
45M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14219 — Item#8, FilmG428 9/14/70 km — 14243

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | MILTON | Middle G. | Last BOLZ |
| 2a. DATE OF DEATH Month Day Year | September 7, 1970 | 2b. HOUR | 945 A.M. |
| 3. SEX | MALE | 4. RACE | WHITE |
| 5. DATE OF BIRTH | FEB. 19, 1903 | 6. AGE (In years last birthday) | 67 YRS. |
| IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | OHIO | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | 9. COUNTY OF DEATH | Wicomico Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hospital |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | MARYLAND | 13b. COUNTY | WORI |
| 13c. CITY OR TOWN | OCEAN CITY | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | |
| 13e. STREET AND NUMBER | 1506 SHAD ROW | | |
| 14. FATHER'S NAME First | GUSTAVE | Middle | Last BOLZ |
| 15. MOTHER'S MAIDEN NAME First | ANTONETTE | Middle | Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown | No | 16b. SOCIAL SECURITY NO. | 282-05-4158 |
| 17. INFORMANT Address | Mrs M.G. Bolz, OCEAN CITY, MD | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Liver Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis, Post Necrotic — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from 8-15, 1970, to 9-7, 1970, that (I) (we) last saw the deceased alive on 9-7 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Joseph C. Fitzgerald M.D. | DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED 9/7/70 |
| 22d. PHYSICIAN'S NAME (Type) | Joseph C. Fitzgerald M.D. | 22e. ADDRESS | Medical Centers, Salisbury, Maryland |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | BURIAL | 23b. DATE 9/10/70 | 23c. NAME OF CEMETERY OR CREMATORY Evergreen | 23d. LOCATION (City or Town) Berlin (County) Worc (State) Md. |
| 24. FUNERAL DIRECTOR | Anna A. Burbage | ADDRESS Berlin Md | 25a. REC'D BY REGISTRAR DATE SEP 9 1970 | 25b. REGISTRAR'S SIGNATURE J. Charles Judge |

VR A15 (4)
45M - 1/69

14220

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14244

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| Bessie | | Bounds | 9 | 22 | 70 | 6:53 A.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Female | White | Oct. 22, 1887 | 82 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | Retired Sec't Office | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | WICOMICO | SALISBURY | YES ☒ NO ☐ | MAIN ST. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| SAMUEL | | Bounds | ELIZABETH | | Wilson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | 213-09-8547 | MR Tommy Bounds | 1116 Vicello Ave SALISBURY, MD. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 22 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) hypertensive cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

diabetes

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 9/21, 19 70, to 9/22, 19 70, that (I) (we) last saw the deceased alive on 9/21 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Alberta Mallay Polin | MD | ☒ | ☐ | ☐ | 9/22/70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| ALBERTA MALLAY POLIN | SALISBURY, MARYLAND. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 9-25-1970 | MARDELA Cemetery | MARDELA WI. MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Hill Funeral Home | Salisbury, md. | SEP 24 1970 | J Charles Judge |

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

14221 — 14245

1

1. DECEASED-NAME (Type or print): First Emerson; Middle Clark; Last Bounds
2a. DATE OF DEATH: Month September; Day 23; Year 70
2b. HOUR: 11:45 P M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Aug. 25, 1911
6. AGE (In years last birthday): 59 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): National Biscuit
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: Maryland
13b. COUNTY: Wicomico
13c. CITY OR TOWN: Salisbury
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 201 Davis Street
14. FATHER'S NAME: First Luther; Middle H.; Last Bounds
15. MOTHER'S MAIDEN NAME: First Recie; Middle A.; Last Banks
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ———
16b. SOCIAL SECURITY NO.: 214-12-5224
17. INFORMANT: Mrs. Louise T. Bounds Address: See Sec 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carinomia of the lung with carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months
DUE TO, OR AS A CONSEQUENCE OF (b): Gram Negative pneumonia with septisemia — days
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1621

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Sept. 15 70, 19__, to Sept 23 70, 19__, that (I) (we) last saw the deceased alive on Sept. 23 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Francis J. Murphy Jr. M.D. DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X] DATE SIGNED: Sept. 23, 1970
22d. PHYSICIAN'S NAME (Type): Francis J. Murphy, Jr. M. D.
22e. ADDRESS: Deer's Head State Hospital Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9-26-1970
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City or Town) (County) (State): Salisbury, Wicomico, Maryland
24. FUNERAL DIRECTOR: Hill Funeral Home ADDRESS: Salisbury, Maryland
25a. REC'D BY REGISTRAR DATE: SEP 28 1970
25b. REGISTRAR'S SIGNATURE: Charles Judge

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14222 — 14246

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| Fredrick | THOMAS | Brown | 9 | 24 | 70 | 1 SST M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Male | White | Aug 2 1896 | 74 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Pa | U.S. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | Retired Farmer | Chickens |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md | Wicomico | Delmar | | R D 3 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| George | E. | Brown | Elise | Schaugberger | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| | | George F. Brown | Camp Hill Pa |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Manth Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Nat while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** thot (I) (this hospital) attended the deceosed from 9-22, 19 70 to 9-24, 19 70, that (I) (we) last saw the deceased alive on 9-24 19 70 and that in (my) (aur) apinian death occurred on the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Wellie R Ellis | | | | | 9-24-70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| BURIAL | 9/26/70 | SPRING HILL Memory Gardens | Hebron | Wicomico | Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE SEP 28 1970 | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| William Mood | Delmar Del | | Charles Judge |

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14223 — 14247

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First / Middle / Last | Marie / Bunting | 2a. DATE OF DEATH Month / Day / Year | September 5 1970 | 2b. HOUR | 8 PM |
| 3. SEX | Female | 4. RACE | White | 5. DATE OF BIRTH | March 25, 1907 |
| 6. AGE (In years last birthday) | 63 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | Delaware | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | |
| 9. COUNTY OF DEATH | Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Housewife |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE | Maryland | 13b. COUNTY | Worcester | 13c. CITY OR TOWN | Ocean City |
| 13d. INSIDE CITY LIMITS? | YES [X] NO [ ] | 13e. STREET AND NUMBER | W. Biscayne Drive | | |
| 14. FATHER'S NAME First / Middle / Last | Archie / Evans | 15. MOTHER'S MAIDEN NAME First / Middle / Last | Maggie Evans | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | No | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | - |
| 17. INFORMANT Address | William E. Bunting Ocean City, Md. | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of peritoneum — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4-5 mons

DUE TO, OR AS A CONSEQUENCE OF

(b): Generalized metastasis

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1589

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. I **certify** that (I) (this hospital) attended the deceased from 5/20/70, 19____, to 9/5/70, 19____, that (I) (we) last saw the deceased alive on 9/5/70 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 22b. SIGNATURE | William B. Long | DEGREE | ATTENDING PHYS. [X] | MED. DIRECTOR [ ] | STAFF PHYS. [ ] | 22c. DATE SIGNED 9/5/70 |
| 22d. PHYSICIAN'S NAME (Type) | William B. Long | 22e. ADDRESS | Salisbury, Md. 21801 | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | September 8, | Bethel Mariner's | Ocean View, Sussex, Del. | |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | SEP 16 1970 | 25b. REGISTRAR'S SIGNATURE J. Charles Judge |
| W. Douglas Melson | Frankford, Del. | | | |

VR A15 (4)
45M - 1/69

1

14234

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#6,FilmG429 10/14/70 km

## CERTIFICATE OF DEATH

14248

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hapitol, give street address): Salisbury Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): Delmar
d. STREET ADDRESS: 808 State St.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: GLADYS Middle: Ellis Last: Calloway
4. DATE OF DEATH: Manth 9 Day 26 Year 19 70
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 21 1903
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Manths / Days
IF UNDER 24 HRS.: Haurs / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or fareign country): Del.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: William C. Ellis
14. MOTHER'S MAIDEN NAME: Fannie Otwell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Walter N. Calloway Address: Delmar, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly ane cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ~~Cerebral Hemorrhage~~ — INTERVAL BETWEEN ONSET AND DEATH: ~~1 day~~
DUE TO (b): Generalized arteriosclerosis — yrs
DUE TO (c): Generalized Carcinomatosis — 6 mos.
1990
Canditians, if any, which gave rise ta immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II af item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Nat While at work ☐
20e. PLACE OF INJURY (Hame, farm, factary, street, affice bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from 8/15, 19 70, to 9/26, 19 70, that (I) (we) last saw the deceased alive on 9/25 19 70, and thot deoth occurred at ____ M, from causes ond on the date stoted above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/20/70
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/30/70
23c. NAME OF CEMETERY OR CREMATORY: St. Stephens Cem
23d. LOCATION (City or Town) (County) (State): Delmar Sussex Del

24. FUNERAL DIRECTOR: Millard Mood ADDRESS: Delmar Del
25a. REC'D BY REGISTRAR DATE: OCT 5 1970
25b. REGISTRAR'S SIGNATURE: J Charles Judge

1
FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14225

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14249

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH / ESTIMATED | 2b. HOUR |
|---|---|---|---|---|
| ROBERT | LEE | CANNON, SR. | 9-12-70 19 | 2:52 P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Male | White | July 24, 1897 | 73 YRS. | | | September 12 19 70 | M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | MARRIED X | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during mast of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | Salesman & Apartment Manager | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES X NO | 142 Truitt Street |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Milbourne | Frances | Cannon | Effie | | Jones |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Wife) | ADDRESS |
|---|---|---|---|---|
| Yes | WW I | 214-10-9959 | Mrs. Helma E. Cannon | same as 13e, Salisbury, Maryland |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

4109

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES NO X |

| 21a. EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remoins described above, held an Autopsy ☐, Inspectian X, Inquiry X, and in my apinian deoth resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE _____ M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

EXAMINER'S NAME (Type) Dr. Earl L. Royer,
ADDRESS (Street, city, town, or county) 409 Camden Ave, Salisbury, Md.

22b. DATE SIGNED September 14 /1970

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 16, 1970 | Wicomico Memorial Park | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | SEP 18 1970 | J. Charles Judge |

VR A15ME (5)
10M - 1/69

4 1

14226

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14251

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M F

| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| William | Sunday | Collier | Sept. 3, 1970 | 3:15 a M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN |
|---|---|---|---|---|---|
| male | negro | March 14, 1914 | 56 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Delaware | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Pine Bluff State Hosp. | auto worker | - |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES ☐ NO ☒ | R#2, Jersey Road |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Robert | - | Collier | Bertha | - | Dashields |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| no | - | 222-01-3707 | records of | Pine Bluff State Hospital |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cerebral vascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown

4369

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that ~~I~~ (this hospital) attended the deceased from Aug. 28, 19 70, to Sept. 3 19 70, that ~~I~~ (we) last saw the deceased alive on Sept. 3 19 70, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~I~~ (we) (did) ~~(did not)~~ view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☐ | MED. DIRECTOR ☒ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| E P Ritchings | | | | | Sept. 3, 1970 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| E. P. Ritchings, M.D. | Pine Bluff State Hospital |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9-6-70 | Green Acres | Salisbury Wico. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| West Funeral Home | Salisbury Md. | SEP 8 1970 | Charles Judge |

VR A15 (4) 45M - 1/69

1
FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MA-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH

14227

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14252

| 1. DECEASED-NAME (Type or Print) First | Middle | Lost |
|---|---|---|
| ELIZABETH | A. | COOPER |

2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month 9 Day 4 Year 1970 — 2b. HOUR 11:50 AM

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| F | W | 7-10-1888 | 82 YRS. | | | | |

2c. DATE PRONOUNCED DEAD Month 9 Day 4 Year 1970 — 2d. HOUR M

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| VA. | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General | HOUSEWIFE | HOME MAKER |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Wicomico | Hebron | YES [X] NO [ ] | 300 Chestnut St. |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| THOMAS | ALMOND | | Unknown | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | None | THOMAS A. COOPER | (SAME AS #13) |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic cardiovascular disease — years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Noturol couses [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined monner [ ]

ACTUAL SIGNATURE Earl L. Royer M.D.

EXAMINER'S NAME (Type) Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.

22b. DATE SIGNED Sept. 5, 1970

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| CREMATION | 9-8-70 | Ft Lincoln Cemetery | Colmar Manor | | Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Chambers Funeral Home, | Washington, D.C. | SEP 14 1970 | J. Charles Judge |

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14228 14253

# CERTIFICATE OF DEATH

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| MARION | HAYWARD | COX, JR. | September | 13 | 1970 | 8:45AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN. |
|---|---|---|---|---|---|---|---|
| Male | White | June 24, 1931 | 39 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | Manager | Service Station |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Tyaskin | YES ☐ NO ☐ | in village |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Marion | Hayward | Cox, Sr. | Ruth | Elizabeth | Watson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Wife) Address |
|---|---|---|
| No | 215-26-4636 | Mrs. Betty Jane Cox, Tyaskin, Maryland |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pseudomonas-Klebsiella Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2wks

4820

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | Yes |

| 21a. ACCIDENT WAS UNDERLYING ☐ DR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this hospital) attended the deceased from 8-25, 19 70, to Sept 13, 19 70, that (I) (we) last saw the deceased alive on 9-13, 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| John T Bulkeley, MD | | ☒ | ☐ | ☐ | September 14, 1970 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Dr. John T. Bulkeley | Pine Bluff Road, Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 16, 1970 | Bivalve Cemetery | Bivalve, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | SEP 18 1970 | J Charles Judge |

VR A15 (4)
30M REV. 1/68

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14223 — 14254

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (carbon paper) pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: MARY | Middle: A. | Last: DASHIELL | 2a. DATE OF DEATH: Month: September Day: 22, Year: 1970 | 2b. HOUR: 4:00 M |
| 3. SEX: Female | 4. RACE: Negro | 5. DATE OF BIRTH: AUG 10, 1886 | 6. AGE (In years last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Nanticoke | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: WICOMICO Md. | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Tyaskin | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: Tyaskin Md. | |
| 14. FATHER'S NAME First: George | Middle | Last: Muller | 15. MOTHER'S MAIDEN NAME First: Fannie | Middle | Last: Ross |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 213-14-1353 | 17. INFORMANT: Clifton Dashiell | Address: Tyaskin, Md. | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bilateral bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO, OR AS A CONSEQUENCE OF (b): Hypertensive arteriosclerotic cardiovascular disease — Years

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Diverticulosis; old cerebral vascular accident

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that X (this hospital) attended the deceased from September 23 1969, to September 22 1970, that X (we) last saw the deceased alive on September 22, 1970, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (did not) view the body after death.

22b. SIGNATURE: L. V. Maldve, M.D. DEGREE — ATTENDING PHYS. ☐ MED. DIRECTDR ☐ STAFF PHYS. ☒ — 22c. DATE SIGNED: 9/22/70

22d. PHYSICIAN'S NAME (Type): L. V. Maldve, M.D. — 22e. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9-26-70 | 23c. NAME OF CEMETERY OR CREMATORY: Nanticoke | 23d. LOCATION (City or Town): Nanticoke | (County): Wico. | (State): Md. |
| 24. FUNERAL DIRECTOR: Loretta B. Jolley | ADDRESS: Salis. Md. | 25a. REC'D BY REGISTRAR DATE: SEP 25 1970 | 25b. REGISTRAR'S SIGNATURE: J. Charles Judge | | |

VR A15 (4) 45M - 1/69

1

14230

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14255

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physicion and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremotion, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: JOHN | Middle: LEWIS | DAUGHERTY / Daugherty | 2a. DATE OF DEATH Month: 9 Day: 5 Year: 70 | 2b. HOUR: 3:41 M | |
| 3. SEX: male / Male | 4. RACE: White | 5. DATE OF BIRTH: Oct. 8, 1895 | 6. AGE (In years last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Mechanic | 12b. KIND OF BUSINESS OR INDUSTRY: Auto repair | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Somerset | 13c. CITY OR TOWN: Marion | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER: RFD | | |
| 14. FATHER'S NAME First: Andrew | Middle: J. | Last: Daugherty | 15. MOTHER'S MAIDEN NAME First: Ann | Middle: Elizabeth | Last: Foringer | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 212-12-3854 | 17. INFORMANT Address: Paul Swift - R.F.D. - Marion, Md. | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes mellitus

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Above-knee amputation | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I **certify** thot (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 9/5 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the couses stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Richard E Hughes | DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ | 22c. DATE SIGNED: 9/8/70 | |
| 22d. PHYSICIAN'S NAME (Type): Richard E. Hughes, M.D. | 22e. ADDRESS: Medical Center - Salisbury, Md. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): burial | 23b. DATE: 9/8/70 | 23c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery | 23d. LOCATION (City or Town) (County) (State): Rehobeth-Somerset-Md. | |
| 24. FUNERAL DIRECTOR: Bradshaw & Sons | ADDRESS: Crisfield, Md. | 25a. RECD BY REGISTRAR DATE: SEP 14 1970 | 25b. REGISTRAR'S SIGNATURE: J Charles Judge | |

VR A15 (4) 45M - 1/69

1

**FOR STATE HEALTH DEPT.**

14231

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14256

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with (form) PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| ROBERT | WAYNE | DENNIS, JR. | 9-10-70 19 | 6:30 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| M | AA | 7-16-18 | 52 YRS. | | | 9 10 70 | 11 A M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Darby Pa. | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Eden | Route 2 | construction worker | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Wicomico | Eden | YES ☐ NO ☒ | Route 2 |

| 14. FATHER'S NAME First Middle Last | 15. MOTHER'S MAIDEN NAME First Middle Last |
|---|---|
| Robert Wayne Dennis, Sr. | Winifred Polk |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | 214-16-4215 | Corpane Winfred Dorman Rt #2 Eden, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Carcinoma of Right Lung, undifferentiated — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

1621

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

**ACTUAL SIGNATURE** Earl L. Royer M.D.

**EXAMINER'S NAME** (Type) Earl L. Royer, M.D.

409 Camden Ave., Salisbury, Md. ADDRESS(Street, city, town, or county)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. **DATE SIGNED** Sept. 10, 1970

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9-13-70 | Friendship United | Allen Wico Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Jolley Funeral Home, Salisbury, Md. | SEP 23 1970 | J Charles Judge |

VR A15ME (5) 10M · 1/69

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (carbon) pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/89

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14232 — 14257

1. DECEASED-NAME (Type or print): First JESSIE; Middle ELIZABETH; Last DETAMORE

2a. DATE OF DEATH: Month September; Day 13; Year 1970

2b. HOUR: 11:10 PM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: March 6, 1918

6. AGE (In years last birthday): 52 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (State or foreign country): MD

7b. CITIZEN OF WHAT COUNTRY?: U. S.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: WICOMICO Md.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Deer's Head State Hospital

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland

13b. COUNTY: Dorchester

13c. CITY OR TOWN: Vienna

13d. INSIDE CITY LIMITS? YES [ ] NO [ ]

13e. STREET AND NUMBER: Church Street

14. FATHER'S NAME: First Erman; Middle C.; Last Willey

15. MOTHER'S MAIDEN NAME: First Elsie; Middle Hughes; Last Willey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

16b. SOCIAL SECURITY NO. (If yes give war or dates of service): 219-03-5526

17. INFORMANT: Eugene Detamore — Address: Vienna MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Squamous cell carcinoma of floor of mouth — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9 months

144X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)

21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that (I) (this hospital) attended the deceased from September 8, 1970, to September 13, 1970, that (I) (we) last saw the deceased alive on September 13, 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: L. V. Maldve, M.D.

DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22c. DATE SIGNED: 9/14/70

22d. PHYSICIAN'S NAME (Type): L. V. Maldve, M.D.

22e. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

23a. BURIAL (CREMATION) REMOVAL (Specify)

23b. DATE: Sept. 16, 1970

23c. NAME OF CEMETERY OR CREMATORY: Vienna

23d. LOCATION (City or Town) (County) (MD): Vienna Dorchester (MD)

24. FUNERAL DIRECTOR: LeCompte Funeral Home

ADDRESS: Cambridge MD

25a. RECD BY REGISTRAR DATE: SEP 18 1970

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

14233

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

Item#23d,FilmG430 11/23/70 kam

14258

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| John | HARRISON | Divel | 9 | 18 | 70 | 10:28 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Male | Caue. | 10-5-1887 | 82 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Pennsylvania | U.S. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Wicomico Nsg. Home | ANTIQUE DEALER | ANTIQUE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☑ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Worcester | Berlin | | RT 2 Box 206 B |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| UNKNOWN | | | UNKNOWN | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| No | | | Mrs. Marjorie Fleming | SAME AS #13 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Adeno carcinoma of Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1621

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Surgery

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 7/7/70 19___, to 9/11/70 19___, that (I) (we) last saw the deceased alive on ___ 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☑ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| | | | | | 9/18/70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 9-21-1970 | GROVE PLACE CEM. | CHILI, MONROE N.Y. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Thomas F. Wallace, Salisbury, Md. | SEP 21 1970 | J. Charles Judge |

VR A15 (4)
45M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14234 — 14259

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: LARRY | Middle: TODD | Last: DIXON | 2a. DATE OF DEATH Month: SEPTEMBER | Day: 23 | Year: 1970 |
| 2b. HOUR: 12 Noon M | | | | | | |
| 3. SEX: MALE | 4. RACE: White | 5. DATE OF BIRTH: December 5, 1893 | 6. AGE (In years last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer | 12b. KIND OF BUSINESS OR INDUSTRY: Farming | | | |
| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET AND NUMBER: R.D. 4, Snow Hill Road | | |
| 14. FATHER'S NAME First: Edward | Middle: Henry | Last: Dixon | 15. MOTHER'S MAIDEN NAME First: Mary | Middle: Elizabeth | Last: Matthews | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 215-38-0868 | 17. INFORMANT: (Wife) | Address: same as 13e | | | |
| | | Mrs. Ida P. Dixon, Salisbury, Maryland | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Uremia — 4 da.

DUE TO, OR AS A CONSEQUENCE OF (b): Pyelitis — 10 da

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

5901

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote | |

22a. **I certify** that (I) (this hospital) attended the deceased from 9/10, 1970, to 9/23, 1970, that (I) (we) last saw the deceased alive on 9/22 1970, and that in (my) (aur) apinian death occurred on the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE: F. Weaver MD — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 9/23/70

22d. PHYSICIAN'S NAME (Type): Frank L. Weaver, M.D. — 22e. ADDRESS: Salisbury, Maryland

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Sept. 26, 1970 | 23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park | 23d. LOCATION (City or Town) (County) (Stote): Salisbury, Wicomico, Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | 25a. REC'D BY REGISTRAR DATE: SEP 28 1970 | 25b. REGISTRAR'S SIGNATURE: J. Charles Judge | | |

VR A15 (R)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

14235 — 14260

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: OSCAR | Middle: THOMAS | Last: EVANS | 2a. DATE OF DEATH: Month: September | Day: 29 | Year: 1970 | 2b. HOUR: 7.45 AM |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: October 21, 1916 | 6. AGE (In years last birthday): 53 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: WICOMICO Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Service Station Attendent | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Delmar | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET AND NUMBER: 209 East Street | | | |
| 14. FATHER'S NAME First: Norman | Middle: J. | Last: Evans | 15. MOTHER'S MAIDEN NAME First: Bessie | Middle: | Last: Gravenor | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes | (If yes give war or dates of service): WW II | 16b. SOCIAL SECURITY NO.: 213-14-1339 | 17. INFORMANT (Wife): Mrs. Helen P. Evans, Delmar, Maryland | Address: same as 13e | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), ond (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | VENTRICULAR FIBRILLATION | 5 min. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY THROMBOSIS | 3 hours |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Arteriosclerosis | unknown |

Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|

22a. **I certify** that (I) (this hospitol) attended the deceased from 2/7, 19 70, to death, 19____, that (I) (we) last saw the deceased alive an 9/29, 19 70, and thot in (my) (aur) opinion death occurred on the dote and hour and from the causes stated obave, (I) (we) (did) (did nat) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Ernest Larmore | | [X] | [ ] | [ ] | September 30/1970 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Dr. Ernest M. Larmore | Grove St., Delmar, Delaware |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | October 2, 1970 | Parsonsburg Cemetery | Parsonsburg, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | OCT 5 1970 | Charles Judge |

VR A15 (4) 30M REV. 1/68

1

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

14236

## CERTIFICATE OF DEATH

15877

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M S-63

**1. PLACE OF DEATH**
a. COUNTY: Wicomico
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PARSONSBURG
c. LENGTH OF STAY IN 1b: All Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
d. STREET ADDRESS: P.O Box 53
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

**3. NAME OF DECEASED** (Type or print): First: Levi; Middle: ; Last: EVERETT

**4. DATE OF DEATH**: Month: 9; Day: 25; Year: 19 70

**5. SEX**: M

**6. COLOR OR RACE**: NEGRO

**7. MARRIED** [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

**8. DATE OF BIRTH**: 2-17-87

**9. AGE** (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Minister

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): HARRISVILL, N.C.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A

**13. FATHER'S NAME**: JACK Everett

**14. MOTHER'S MAIDEN NAME**: ZENDORA ?

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give wer or detes of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Ophelia Ennis Address: P.O.Box 53, PARSONSBURG

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: Indefinite

4409

DUE TO (b): Arteriosclerosis — Indefinite

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES [ ] NO [ ]

**20a. ACCIDENT WAS UNDERLYING** [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work [ ] Not While at work [ ]

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 3 Jan 1968 to 25 Sept 19 70, that (I) (we) last saw the deceased alive on 25 Sept 19 70 and that death occurred at 9 a.m., from the causes and on the date stated above.

**22a. SIGNATURE**: F. Purnell, M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

**22b. DATE SIGNED**

**22c. PHYSICIAN'S NAME** (Type): F. A. Purnell, MD

**22d. ADDRESS**: 652 W Main St, Salisbury, Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL

**23b. DATE THEREOF**: 9-30-70

**23c. NAME OF CEMETERY OR CREMATORY**: GREEN ACRES

**23d. LOCATION** (City, town or county) (State): SALISBURY Md.

**24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS**: Jolley Memorial Chapel - Salis. Md,

**25a. REC'D BY REGISTRAR** DATE: OCT 8 1970

**25b. REGISTRAR'S SIGNATURE**: J Charles Judge

1

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

14237

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14261

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH / ESTIMATED | Month Day Year | 2b. HOUR |
|---|---|---|---|---|---|
| FRANKLIN | RILE | FOW | ESTIMATED ☐ | Sept. 24 1970 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Male | White | Dec. 14, 1897 | 72 YRS. | | | September 24 1970 | M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Pennsylvania | USA | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | 204 Carrollton Avenue | Architect & contractor | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES ☒ NO ☐ | 204 Carrollton Avenue |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| John | H. | Fow | Mary | B. | Rile |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Daughter) | ADDRESS |
|---|---|---|---|---|
| Yes | WW I | 127-09-8924 | Mrs. Barbara Kuter, Plymouth Meeting, Pa. | 143 Plymouth Road |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute cardiac decompensation

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic heart disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify thot I took chorge of the remoins described obove, held on Autopsy ☐, Inspection ☒, Inquiry ☒, ond in my opinion deoth resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Philip A. Insley M.D.

EXAMINER'S NAME (Type) Dr. Philip A. Insley

ADDRESS (Street, city, town, or county) 116 E. Main St., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED September 27 /1970

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Cremation | 9/26/70 | Silverbrook Cemetery | Wilmington, Delaware |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | SEP 28 1970 | J Charles Judge |

VR A15ME (5)
10M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14238 — 14262

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page) 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| HETTIE | ANN | FOXWELL | SEPT. | 21 | 70 | 8:45 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Female | White | 3 June 1878 | 92 YRS. | 3 | 8 | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Siloam, Md. | U S A | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | R.D.#1 Camden Ave.Ext. | House Work | None |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | | R.D.#1 Camden Ave.Ext. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| THOMAS | THEODORE | SMITH | JULIA | - - | JONES |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No | 214-46-4994 | Mr.Willie B.Foxwell(Son)700 S.Division Street Salisbury, Maryland |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive C.V. Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4122
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | N/A |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | N/A | N/A | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from Jan., 1970, to 9/21, 1970, that (I) (we) last saw the deceased alive on 9/21 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| W B Smith | MD | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | Sept. 23/1970 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Dr.William B.Smith | Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE. | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept.24/1970 | Wicomico Memorial Park | Salisbury, Maryland |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| HOLLOWAY & COMPANY | SALISBURY, MARYLAND | SEP 25 1970 | J Charles Judge |

VR A15 (4) 45M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14239 — 15883

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First MARY; Middle L.; Last GORDY
2a. DATE OF DEATH: Month September; Day 30; Year 1970
2b. HOUR: M
3. SEX: F
4. RACE: White
5. DATE OF BIRTH: Oct. 14, 1909
6. AGE (In years last birthday): 60 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): DElaware
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Salisbury Nursing Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): housewife
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Delaware
13b. COUNTY: Sussex
13c. CITY OR TOWN: Laurel
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 134 Oak Lane Drive
14. FATHER'S NAME: First Larry; Middle; Last Brittingham
15. MOTHER'S MAIDEN NAME: First Eva; Middle Benson; Last Brittingham
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 221 03 5060
17. INFORMANT: John E. Brittingham; Address: Lakeside Manor Laurel Del.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 hr
DUE TO, OR AS A CONSEQUENCE OF
(b): Generalized arteriosclerosis — yes.
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4339

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 7/15, 1970, to 9/30, 1970, that (I) (we) last saw the deceased alive on 9/30 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: Earl M. Beardsley — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10/3/70
22d. PHYSICIAN'S NAME (Type): Dr. Earl M. Beardsley
22e. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct. 2, 1970
23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Laurel Sussex Del.
24. FUNERAL DIRECTOR: H. B. Wisharoon
ADDRESS: Laurel, Delaware
25a. REC'D BY REGISTRAR DATE: OCT 9 1970
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 45M - 1/69

1

**FOR STATE HEALTH DEPT.**

14240

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14263

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form [illegible]. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| MARTHA | BEATRICE JONES | GOSLEE | 9-15-70 19 | 3:30 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| F | AA | 1-18-1899 | 71 YRS. | | | 9 15 19 70 | P.M. |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Sharptown | U.S.A | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Wicomico | Mardela Sp. | YES ☐ NO ☐ | Route 1, Box 122 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| George | | Jones | Annie | | Hopkins |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (daughter) ADDRESS |
|---|---|---|---|
| | | 220-01-5321 | Hortense Stanley, as per #13 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Crushed chest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. 8120

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | 2:40 P.M. 9-15-70 | Driver of auto involved in collision. |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | highway, intersection, Rt. 13 & 54, Delmar, | Del. |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED Sept. 17, 1970

EXAMINER'S NAME (Type) Earl L. Royer, M.D. ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| burial | 9-19-70 | Zion United Methodist | Sharptown, Wic., Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Jolley Funeral Home, Salisbury, Md. | SEP 23 1970 | J. Charles Judge |

VR A15ME (S)
10M - 1/69

1
FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

14241

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14264

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| VIRGINIA | DELL | GRAHAM | 9-15-70 19 | 3:27 P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| F | W | 1-1-1884 | 86 YRS. | | | 9 15 19 70 | " M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| DELAWARE | USA | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General | HOUSEWIFE | OWN HOME |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Del. | SUSSEX | Seaford | YES ☐ NO ☐ | Methodist Manor House |

| 14. FATHER'S NAME First Middle Last | 15. MOTHER'S MAIDEN NAME First Middle Last |
|---|---|
| ASA - MERRITT | CAROLINE QUILLIN MERRITT |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| NO | | URIAS GRAHAM - SEAFORD DEL. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Crushed chest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ½ hr.
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
8121
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | 2:40 P.M. 9-15-70 | Passenger in auto involved in collision. |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | Highway, | intersection of Rt. 13 & 54, Delmar Del. |

22a. **I certify** that I took charge of the remains described obave, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion deoth resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED Sept. 17, 1970

EXAMINER'S NAME (Type) Earl L. Royer, M.D. ADDRESS(Street, city, town, or county) 409 Camden Ave., Salisbury, Md.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | SEPT 19, 1970 | ODD FELLOWS Cem. | SEAFORD SUSSEX DEL. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Pamela M. Watson Watson Funeral Home, Seaford, Del. | SEP 21 1970 | Charles Judge |

VR A15ME (5)
10M - 1/69

Items 18,22a
Film C439 9/29/70,cr

14242

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14265

1 FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: VINCENT | Middle: PARKS | Last: GREENE | 2a. DATE KNOWN OF ESTIMATED ☒ Month Day Year: 9-17-70 | 2b. HOUR: 4 P M | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: 8/9/23 | 6. AGE (In years last birthday): 47 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year: September 17 1970 | 2d. HOUR: 6:30 P M |
| 7a. BIRTHPLACE (State or foreign country): Virginia | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: WICOMICO Md. | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 1932 Pineway | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Merchant Marine | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 1932 Pineway | |
| 14. FATHER'S NAME First: Leroy | Middle: B. | Last: Greene, Sr. | 15. MOTHER'S MAIDEN NAME First: Hazel | Middle: Collins | Last: Greene |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS: Mrs. Marion White Salisbury, Md. | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

PART I. DEATH WAS CAUSED BY:

3039

IMMEDIATE CAUSE (a): Acute Alcoholism

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** thot I took charge of the remoins described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M. D.

ADDRESS(Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. **DATE SIGNED**: September 18/1970

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9/20/70 | 23c. NAME OF CEMETERY OR CREMATORY: Parksley Cemetery | 23d. LOCATION (City or Town) (County) (State): Parksley Accomack Va. | |
| 24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR DATE: SEP 23 1970 | 25b. REGISTRAR'S SIGNATURE: Kinsley Judge | |

VR A15ME (5)
10M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14243 — 14266

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: HAZEL | Middle: JACKSON | Last: Grubb | 2a. DATE OF DEATH Month: September Day: 6 Year: 1970 |
| 2b. HOUR: 4:30 P M | 3. SEX: Female | 4. RACE: WHITE | 5. DATE OF BIRTH: II/I6,I9I6 |
| 6. AGE (In years lost birthday): 53 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY: SAME |
| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) STATE: Md. | 13b. COUNTY: WICOMICO | 13c. CITY OR TOWN: SALISBURY | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] |
| 13e. STREET AND NUMBER: RT. #I KINGSWOOD DRIVE SALISBURY, Md. | | | |
| 14. FATHER'S NAME First: JOHN | Middle: (N.M.I.) | Last: JACKSON | 15. MOTHER'S MAIDEN NAME First: MARTHA Middle: (N.M.I.) Last: CHESSER |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO | (If yes give war or dates of service): NO | 16b. SOCIAL SECURITY NO.: 212 32 3768 | 17. INFORMANT: RICHARD A. GRUBB Address: RT. #I KINGSWOOD DRIVE SALISBURY, MARYLAND |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hodgkins Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last. 201X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from 9-6, 19 70, to 9-6, 19 70 / that (I) (we) last saw the deceased alive on 9-6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: William R. Ellis DEGREE | ATTENDING PHYS. [✓] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 9-6-70 | |
| 22d. PHYSICIAN'S NAME (Type): WILLIAM R. ELLIS | 22e. ADDRESS: PINE BLUFF RD. SALISBURY | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 9/9/1970 | 23c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEMETERY | 23d. LOCATION (City or Town) (County) (State): HAVRE DE GRACE, HARFORD, Md. | |
| 24. FUNERAL DIRECTOR: PENNINGTON & SON, HAVRE DE GRACE, MARYLAND | ADDRESS: Pennington & Son, Havre de Grace, Md. | 25a. REC'D BY REGISTRAR DATE: SEP 10 1970 | 25b. REGISTRAR'S SIGNATURE: J. Charles Judge | |

VR A15 (4) 45M - 1-69

1

**FOR STATE HEALTH DEPT.**

14244

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14267

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form MB. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: JAMES | Middle: VIRGIL | Last: HANCOCK, JR. | 2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month 9 Day 4 Year 19 70 | | 2b. HOUR 4:30 M | |
| 3. SEX: Male | 4. RACE: W | 5. DATE OF BIRTH: 1-20-59 | 6. AGE (In years last birthday): 11 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month 9 Day 4 Year 19 70 | 2d. HOUR 11 M |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): School Boy | 12b. KIND OF BUSINESS OR INDUSTRY: --- | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET AND NUMBER: Rt. 4, Johnson Rd. | | | |
| 14. FATHER'S NAME First: James | Middle: Virgil | Last: Hancock | 15. MOTHER'S MAIDEN NAME First: Mary | Middle: Kathleen | Last: Richardson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Father) | ADDRESS: same as 13e<br>Mr. James V. Hancock, Salisbury, Md. | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Asphyxia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

9139

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] | |
| 21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR 4:15 P.M. 9-4-70 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Digging tunnel & caved in on him. | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): own home | 21f. LOCATION Street or R.F.D. No.: Johnson Rd., | City or Town: Salisbury, | County: Wicomico, | State: Md. |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X] Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): Earl L. Royer, M.D. ADDRESS(Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

22b. **DATE SIGNED**: Sept. 5, 1970

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 8, 1970 | Springhill Memory Gardens, | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Holloway Funeral Home, Salisbury, Md. | SEP 9 1970 | Charles Judge |

VR A15ME (5)
10M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14245 — 14268

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| George | T. | Holland | Sept. | 5 | 1970 | 7:15 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| Male | White | March 27, 1885 | 85 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Deer's Head State Hospital | Salesman | Meat Products |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | | 315 Princeton Ave. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| George | Steward | Holland | Virginia | -- | Blades |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| no -- | 213-05-2107 | George T. Holland, Salisbury, Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cereeral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 Hrs.

DUE TO, OR AS A CONSEQUENCE OF

(b) Gram Negative Pneumonia with Septsemia — 12 Hrs.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4339

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | Yes |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from August 26, 1970, to September 5, 1970, that (I) (we) last saw the deceased alive on September 5, 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~xxxxx~~ view the body after death.

| 22b. SIGNATURE | DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ | 22c. DATE SIGNED |
|---|---|---|
| Francis J. Murphy jr MD | | 9/5/70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Francis J. Murphy, M.D. | Deer's Head State Hospital, Salisbury, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9-9-1970 | First Baptist | Pocomoke City-Wor.-Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Robert H. Watson | Pocomoke City, Md. | SEP 14 1970 | Richard Judge |

VR A15 (2) 45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

14246 — 14269

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | ROBERT | Middle POWELL | Last HOLT |
| 2a. DATE OF DEATH Month Day Year | September 21 1970 | 2b. HOUR | 3:35A |
| 3. SEX | Male | 4. RACE | White |
| 5. DATE OF BIRTH | 9/10/91 | 6. AGE (In years last birthday) | 79 YRS. |
| IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? | USA |
| 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | 9. COUNTY OF DEATH | WICOMICO Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hospital |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Foreman | 12b. KIND OF BUSINESS OR INDUSTRY | Lumber Mill |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | 13b. COUNTY | Wicomico |
| 13c. CITY OR TOWN | Salisbury | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | |
| 13e. STREET AND NUMBER | 708 Baker Street | | |
| 14. FATHER'S NAME First | Alfred | Middle | Holt Last |
| 15. MOTHER'S MAIDEN NAME First | Henrietta | Middle | Somers Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | unknown | 16b. SOCIAL SECURITY NO. | 214-10-8233 |
| 17. INFORMANT (Wife) Address | Mrs. Clara M. Holt, Salisbury, Maryland | | same as 13e |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma of prostate with metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mon.
DUE TO, OR AS A CONSEQUENCE OF
(b) Adenoid cystic Carcinoma of neck. — 6 mon.
DUE TO, OR AS A CONSEQUENCE OF
(c)

185X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Arteriosclerotic heart disease

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 9/18/70 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | Needle Biopsy of Prostate |
| 20a. AUTOPSY? YES ☐ NO ☒ | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 9/10/70, 19____, to 9/21/70, 19____, that (I) (we) last saw the deceased alive on 9/21/70 19____, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ ~~(did not)~~ view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Raymond M. Yow M.D. | DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: September 22 /1970 |
| 22d. PHYSICIAN'S NAME (Type) | Dr. Raymond M. Yow ~~Dr. Walter Dr. DeVault, Jr.~~ | 22e. ADDRESS | Salisbury, Maryland |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | Sept. 23, 1970 | Parsons Cemetery | Salisbury, Wicomico, Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS | HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | 25a. REC'D BY REGISTRAR DATE | SEP 24 1970 | 25b. REGISTRAR'S SIGNATURE J. Charles Judge |

VR A15 (4)
30M REV. 1/68

1

**FOR STATE HEALTH DEPT.**

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with 10 mm. PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH

14247

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14270

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| EDWARD | | JACKSON | 9-12-70 19 | 5:30 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| M | AA | 3-10-03 | 67 YRS. | | | 9 12 1970 | 11 M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. COUNTY OF DEATH |
|---|---|---|---|
| N.J. | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Wicomico | Salisbury | YES ☐ NO ☐ | 122 Delaware St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| unknown | | | Mary | | Stanley |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (son) | ADDRESS |
|---|---|---|---|
| | | Charles Carroll | 604 W. Main St. Salisbury, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Earl L. Royer M.D.

EXAMINER'S NAME (Type) Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.

22b. **DATE SIGNED** Sept. 17, 1970

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9-15-70 | Bylon Unit. | Sharptown, Wico. Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Jolley Funeral Home, Salisbury, Md. | SEP 23 1970 | J Charles Judge |

1

14248

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14271

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First / Middle / Lost | Ulysses / Waymond / Jackson | 2a. DATE OF DEATH Month Day Year | Sept. 16, 1970 |
| 2b. HOUR | 1:25 M | | |
| 3. SEX | male | 4. RACE | negro |
| 5. DATE OF BIRTH | May 26, 1903 | 6. AGE (In years last birthday) | 67 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | 9. COUNTY OF DEATH | Wicomico Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Pine Bluff State Hosp. |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | care taker | 12b. KIND OF BUSINESS OR INDUSTRY | - |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | 13b. COUNTY | Dorchester |
| 13c. CITY OR TOWN | Cambridge | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | |
| 13e. STREET AND NUMBER | R#2, Box 95 | | |
| 14. FATHER'S NAME First / Middle / Lost | David - Jackson | 15. MOTHER'S MAIDEN NAME First / Middle / Lost | Mary Louise Cornish |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | no | (If yes give war or dates of service) | - |
| 16b. SOCIAL SECURITY NO. | 218-20-6505 | 17. INFORMANT Address | records of Pine Bluff State Hospital |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that I (this hospital) attended the deceased from June 22, 1970, to Sept.16, 1970, that I (we) last saw the deceased alive on Sept. 16 1970 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | E P Ritchings | DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [X] STAFF PHYS. [ ] | 22c. DATE SIGNED: Sept.16,1970 |
| 22d. PHYSICIAN'S NAME (Type) | E. P. Ritchings, M.D. | 22e. ADDRESS | Pine Bluff State Hospital |

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | BURIAL | 23b. DATE | 9/19/70 | 23c. NAME OF CEMETERY OR CREMATORY | EAST NEW MARKET |
| 23d. LOCATION (City or Town) | EAST NEW MARKET | (County) | DOR. | (State) | M D. |
| 24. FUNERAL DIRECTOR | Frederick C. Sylvain | ADDRESS | ST. ADELAIR F. HOME CAMBRIDGE, MD. | 25a. REC'D BY REGISTRAR DATE | SEP 21 1970 |
| 25b. REGISTRAR'S SIGNATURE | J Charles Judge | | | | |

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14249

# CERTIFICATE OF DEATH

14272

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funerol director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| RANDOLPH | | JENKINS | September 21 1970 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | 9/27/05 | 64 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Salisbury Nursing Home | Plumber | Plumbing |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Parsonsburg | YES ☐ NO ☐ | R.D. 1, Box 21 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Edgar | Durand | Jenkins | Lucy | May | Willing |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Wife) | Address |
|---|---|---|---|---|
| Yes | WW II | 214-10-9642 | Mrs. Myrtle E. Jenkins, Parsonsburg, Md. | same as 13e |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of bladder c

DUE TO, OR AS A CONSEQUENCE OF (b) widespread metastasis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 188X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 9/18, 1970, to 9/21, 1970, that (I) (we) last saw the deceased alive on 9/22, 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| John Beardsley. | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | September 22, 1970 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Dr. E. M. Beardsley | Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 24, 1970 | Parsons Cemetery | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | SEP 24 1970 | J. Charles Judge |

VR A15 (4)
30M REV. 1/68

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14250 — 14273

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: SOPHIE | Middle: | Last: JOHNSON | 2a. DATE OF DEATH Month Day Year: September 15, 1970 | 2b. HOUR: 5:15 PM |
| 3. SEX: Female | 4. RACE: Negro | 5. DATE OF BIRTH: Sept. 14, 1896 | 6. AGE (In years last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: WICOMICO Md. | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Domestic | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Hebron | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: Box 407 | |
| 14. FATHER'S NAME First: Carr | Middle: | Last: Handy | 15. MOTHER'S MAIDEN NAME First: Julia | Middle: | Last: Conway |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Alfred Johnson | Address: Hebron Md. | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of esophagus with metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year

150X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that I (X) (this hospital) attended the deceased from September 1 19 70, to September 15 19 70, that I (we) last saw the deceased alive on September 15, 19 70, and that in my (our) opinion death occurred on the date and haur and from the causes stated above, (X) (we) (did) (XXXX) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: L. V. Maldve, M.D. | DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X] | 22c. DATE SIGNED: 9/16/70 | |
| 22d. PHYSICIAN'S NAME (Type): L. V. Maldve, M.D. | 22e. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9/19/ 70 | 23c. NAME OF CEMETERY OR CREMATORY: Church Cemetery | 23d. LOCATION (City or Town) (County) (State): White Heaven Wicomico Md | |
| 24. FUNERAL DIRECTOR: Clinton F. Stewart | ADDRESS: Salisbury Md | 25a. REC'D BY REGISTRAR DATE: SEP 21 1970 | 25b. REGISTRAR'S SIGNATURE: J Charles Judge | |

VR A15 (4)
45M - 1/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14251 14274

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Ola | Middle: B. W. | Last: Jones | 2a. DATE OF DEATH Month: September Day: 25 Year: 1970 | 2b. HOUR 11:30 PM | | |
| 3. SEX: Female | 4. RACE: Negro | 5. DATE OF BIRTH: July 18, 1891 | 6. AGE (In years last birthday) 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): Marion | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Somerset | 13c. CITY OR TOWN: Marion Station | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER | | |
| 14. FATHER'S NAME First: William | Middle: | Last: Whittington | 15. MOTHER'S MAIDEN NAME First: Emma | Middle: | Last: Scarbough | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. 215-01-0090 | 17. INFORMANT: Joel Jones | Address: Marion Sta., Md. 21838 | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli — Several days

DUE TO, OR AS A CONSEQUENCE OF

(b) Adeno Carcinoma of Stomach with Extensive Metastases to Liver — Several years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1519

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Old CVA - Rt. Hemiparesis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from September 15 19 70, to September 25 19 70, that (I) (we) last saw the deceased alive on September 25 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ | 22c. DATE SIGNED |
|---|---|---|
| Charles H. Winnacott M.D. | | 9/26/70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Charles H. Winnacott, M.D. | Deer's Head State Hospital, Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 29'70 | Family Cemetery | Marion Sta., Som. Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Charles W. Ward | Marion Sta. Md. | SEP 30 1970 | J. Charles Judge |

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14252 — 14275

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: SALLY | Middle: MINNIE BELLE (MORRIS) | Last: JONES | 2a. DATE OF DEATH Month Day Year: September 24, 1970 | 2b. HOUR: 3:30AM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: January 19, 1881 | 6. AGE (In years last birthday): 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: WICOMICO Md. | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Trimmer | 12b. KIND OF BUSINESS OR INDUSTRY: Shirt Factory | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER: 768 South Division Street |
| 14. FATHER'S NAME First: Merrill | Middle | Last: Morris | 15. MOTHER'S MAIDEN NAME First: Mary | Middle: Hester Last: Holman |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214-10-7751 | 17. INFORMANT (Daughter) Box 944 | Address: 830 S. Div. St. Mrs. Gladys J. Dickerson, Salisbury, Md. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral thrombosis — Approximate interval between onset and death: Days

DUE TO, OR AS A CONSEQUENCE OF

(b): Gram negative pneumonia with septicemia — Days

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 486X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes mellitus

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from July 19, 19 67 to September 24, 19 70, that (I) (we) last saw the deceased alive on September 24, 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Francis J. Murphy, Jr., M.D. — DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22c. DATE SIGNED: 9/24/70

22d. PHYSICIAN'S NAME (Type): Francis J. Murphy, Jr., M.D. — 22e. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Sept. 26, 1970 | 23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park | 23d. LOCATION (City or Town) (County) (State): Salisbury, Wicomico, Maryland | |
| 24. FUNERAL DIRECTOR: HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | ADDRESS | 25a. RECEIVED BY REGISTRAR DATE: SEP 28 1970 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | |

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1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14253 — 14276

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: THOMAS | Middle: FRANK | Last: JONES | 2a. DATE KNOWN OF DEATH ESTIMATED ☒ Month Doy Year: 9-21-70 19 | 2b. HOUR: 2 A M | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: April 18, 1879 | 6. AGE (In years last birthday): 91 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month 9 Doy 21 Year 19 70 — 2d. HOUR: 6 A M |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 704 S. Div. St., | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired Cabinet Makers Carp. | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 704 S. Div. St., | | |
| 14. FATHER'S NAME First Middle Last: Jacob Robert Jones | 15. MOTHER'S MAIDEN NAME First Middle Last: Susan Bloodsworth | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. | (If yes give war or dates of service): -------- | 16b. SOCIAL SECURITY NO.: 214-10-9182 | 17. INFORMANT ADDRESS: Mrs. Wenona Ward, See Sec 13 | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autapsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: 9- 21, 1970

EXAMINER'S NAME (Type): Dr. Earl L. Royer Camden Ave., Salisbury, Maryland Wicomico

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9-23-1970 | Parsons Cemetery | Salisbury, Maryland Wicomico |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Hill Funeral Home Salisbury, Maryland | SEP 24 1970 | J Charles Judge |

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# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14254 — 14277

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers; pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| EDITH | | KOTOWSKI | September | 10, | 1970 | 10:40 A |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Female | White | June 12, 1891 | 79 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Springfield, Mass. U.S.A. | | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Deer's Head State Hospital | Housewife | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Caroline | Greensboro | YES ☐ NO ☒ | Maple Avenue |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Frank Cook | | Smith | Anna | | Kinnon |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No | 094-14-2857 | Hospital Records Salisbury, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary Embolus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: - -

426X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Kyphoscoliotic Cardiopulmonary Disease — Years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cachexia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (X) (this hospital) attended the deceased from August 27, 1970, to September 10, 1970, that (I) (X) (we) last saw the deceased alive on September 10, 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. XXX

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| L. V. Maldve | M.D. | ☐ | ☐ | ☒ | 9/10/70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| L. V. Maldve, M.D. | Deer's Head State Hospital, Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9-14-70 | Greensboro | Greensboro, Caroline, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| J. E. Boulais Greensboro, Md. | SEP 14 1970 | J. Charles Judge |

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14255 — 14278

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: LAURA | Middle: MAMIE | Last: LALLY | 2a. DATE OF DEATH Month: SEPTEMBER Day: 29 Year: 1970 |
| 2b. HOUR: 4 P. M. | | | |
| 3. SEX: FEMALE | 4. RACE: White | 5. DATE OF BIRTH: July 27, 1906 | 6. AGE (In years last birthday): 64 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Bookkeeper | 12b. KIND OF BUSINESS OR INDUSTRY: Funeral Home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Arizona | 13b. COUNTY: Maricopa | 13c. CITY OR TOWN: Phoenix | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ |
| 13e. STREET AND NUMBER: 30 West Edgemont Ave. | | | |
| 14. FATHER'S NAME First: Gordon | Middle: William | Last: Adkins | 15. MOTHER'S MAIDEN NAME First: Laura |
| Middle: Gertrude | Last: Martin | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214-10-7622 | 17. INFORMANT (Brother) Box 158 Address R.D. 2 Mr. John J. Adkins, Snow Hill, Maryland |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
518X
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote | |

22a. I **certify** that (I) (this hospital) attended the deceased from 9-4, 19 70, to 9-29, 19 70, that (I) (we) last saw the deceased alive on 9-29, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Wilbur R. Ellis Jr. | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 9-29-70 | |
| 22d. PHYSICIAN'S NAME (Type): Dr. Wilbur R. Ellis, Jr. | 22e. ADDRESS: Salisbury, Maryland | | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 10/2/70 | 23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery | 23d. LOCATION (City or Town) (County) (Stote): Phoenix, Arizona |
| 24. FUNERAL DIRECTOR: HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | ADDRESS | 25a. REC'D BY REGISTRAR DATE: OCT 2 1970 | 25b. REGISTRAR'S SIGNATURE: J. Charles Judge |

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45M - 1/69

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14256 — 14279

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, take the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 haurs after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| EMMETT | D. | LAYTON | September 23, 1970 | 3:05 P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | Dec. 7, 1880 | 89 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Md. | U. S. A. | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of wark dane during mast of warking life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Deer's Head State Hospital | Farmer | Farmer |

| 13a. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Caroline | Federalsburg | YES ☐ NO ☒ | rural |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Beauchamp | | Layton | Martha | | Reed |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, ar unknawn) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| no | no | 274-12-4445 A. | James Layton | Federalsburg, |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly ane cause per line far (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

450x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic brain syndrome — Years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Carcinoma of the prostate

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☒ NO ☐ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 ar Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Nat while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street ar R.F.D. Na. | City ar Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from September 16 19 70, to September 23 19 70, that (I) (we) last saw the deceased alive an September 23, 19 70 and that in ~~(my)~~ (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) ~~(did not)~~ view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Francis J. Murphy, Jr. | M.D. | ☐ | ☐ | ☒ | 9/23/70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Francis J. Murphy, Jr., M.D. | Deer's Head State Hospital, Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 27 | Burrsville Cemetery | Burrsville Del. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Edna Williamson | Federalsburg Md. | OCT 6 1970 | J. Charles Judge |

VR A15 (4) 45M · 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14257 — 14280

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Susie | Middle: K | Last: LECATES | 2a. DATE OF DEATH Month: SEPTEMBER | Day: 28 | Year: 1970 |
| 2b. HOUR: 10 M | | | | | | |
| 3. SEX: FEMALE | 4. RACE: White | 5. DATE OF BIRTH: MAY 14, 1890 | 6. AGE (In years last birthday): 80 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): Md | 7b. CITIZEN OF WHAT COUNTRY?: U.S. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWORK | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md | 13b. COUNTY: WICOMICO | 13c. CITY OR TOWN: DELMAR | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 804 STATE ST. | | |
| 14. FATHER'S NAME First: Stokley | Middle: | Last: Figgs | 15. MOTHER'S MAIDEN NAME First: UNKNOWN | Middle: | Last: | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 221-07-2400 | 17. INFORMANT: Marion H. Lecates | Address: Delmar Md | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. I **certify** that (I) (this hospital) attended the deceased from 9-28, 19 70 to 9-28, 19 70, that (I) (we) last saw the deceased alive on 9-28 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | |
|---|---|---|---|---|
| 22b. SIGNATURE: William O Elles | DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 9-29-70 | | |
| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 10/2/70 | 23c. NAME OF CEMETERY OR CREMATORY: Melson Cem | 23d. LOCATION (City or Town) (County) (State): Delmar Wicomico Md. | |
| 24. FUNERAL DIRECTOR: William J Ward | ADDRESS: Delmar | 25a. REC'D BY REGISTRAR DATE: OCT 5 1970 | 25b. REGISTRAR'S SIGNATURE: J Charles Judge | |

VR A15 (4)
45M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14258 — 14281

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or ottending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physicion and completely filled in by the funerol director, page 3 should be detached for use as the buriol-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| Laura | Jane | LITTLETON | 9 - | 12 - | 70 | 5:45 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Female | White | March 26, 1892 | 78 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | Housewife | own home |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Willards | YES ☐ NO ☒ | RFD |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Joseph | Baker | | Naomi | Baker | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| x | x | x | Denver Littleton | Willards, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) General vascular maligny
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Cardiovascular Renal
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last. 4124

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this hospital) attended the deceased from 9-4-, 19 70, to 9-12-, 19 70, that (I) (~~we~~) last saw the deceased alive an 9-11- 19 70, and that in (my) (~~our~~) apinian death occurred on the date and haur and from the causes stated abave, (I) (~~we~~) (~~did~~) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| James L. Cappeman | MD | ☒ | ☐ | ☐ | 9-15-70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | Medical Center Salisbury Md |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/14/70 | New Hope | Willards, Wicomico, Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Tilp Whaley | Selbyville, Del. | SEP 21 1970 | J. Charles Judge |

VR A15 (4)
45M - 1/69

1

14259

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14282

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First / Middle / Lost | SADIE / DYKES / LONG | 2a. DATE OF DEATH Month Day Year | SEPTEMBER 27 1970 |
| 2b. HOUR | 1 35 P.M. | | |
| 3. SEX | Female | 4. RACE | White |
| 5. DATE OF BIRTH | June 21, 1883 | 6. AGE (In years last birthday) | 87 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | 9. COUNTY OF DEATH | Wicomico Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hospital |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Sales Clerk | 12b. KIND OF BUSINESS OR INDUSTRY | Ladies Apparel |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | 13b. COUNTY | Worcester |
| 13c. CITY OR TOWN | Pocomoke | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | |
| 13e. STREET AND NUMBER | 203 Linden Avenue | | |
| 14. FATHER'S NAME First / Middle / Lost | Franklin / -- / Dykes | 15. MOTHER'S MAIDEN NAME First / Middle / Lost | Matilda / -- / Miller |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | No | (If yes give war or dates of service) | -- |
| 16b. SOCIAL SECURITY NO. | 212-10-8399 | 17. INFORMANT Address | John W. Long, Cherry Hill, New Jersey |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebrovascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 11 days

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last. 4/22

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease — years

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Manth Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I), (this hospital) attended the deceased from 9-13, 1970, to 9-24, 1970, that (I) (we) last saw the deceased alive on 9-23 1970, and that in my (our) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | John T. Bulkeley M.D. | DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (Type) | John T. Bulkeley, M.D. | 22e. ADDRESS | Salisbury, Maryland |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | 9-26-1970 | Pitts Creek Presbyterian | Pocomoke City-Wor.-Md. | |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE | |
| Robert M. Watson | Pocomoke City, Md. | SEP 28 1970 | Charles Judge | |

Robert M. Watson

VR A15 (4) 45M - 1/69

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

14260

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14283

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: WILLIS | Middle: BARD | Last: LORD | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] | Month: 9 | Day: 10 | Year: 1970 | 2b. HOUR: 9 P M | |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH: 2-12-12 | 6. AGE (In years last birthday): 58 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | 2c. DATE PRONOUNCED DEAD: Month 9 Day 10 Year 1970 | | 2d. HOUR: 11 M | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Peninsula General | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Salesman | 12b. KIND OF BUSINESS OR INDUSTRY: Machinery | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 218 S. Pineway | | | | | |
| 14. FATHER'S NAME First: John | Middle: Fieldy | Last: Lord | 15. MOTHER'S MAIDEN NAME First: Bertha | Middle: Mae | Last: Nelson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes | (If yes give war or dates of service): WW II | 16b. SOCIAL SECURITY NO.: 216-09-0874 | 17. INFORMANT: Mrs. Anna L. Lord - same as 13 abcde | ADDRESS | | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute pulmonary edema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary occlusion — hours

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinian death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Hamicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

409 Camden Ave., Salisbury, Md. ADDRESS (Street, city, town, or county)

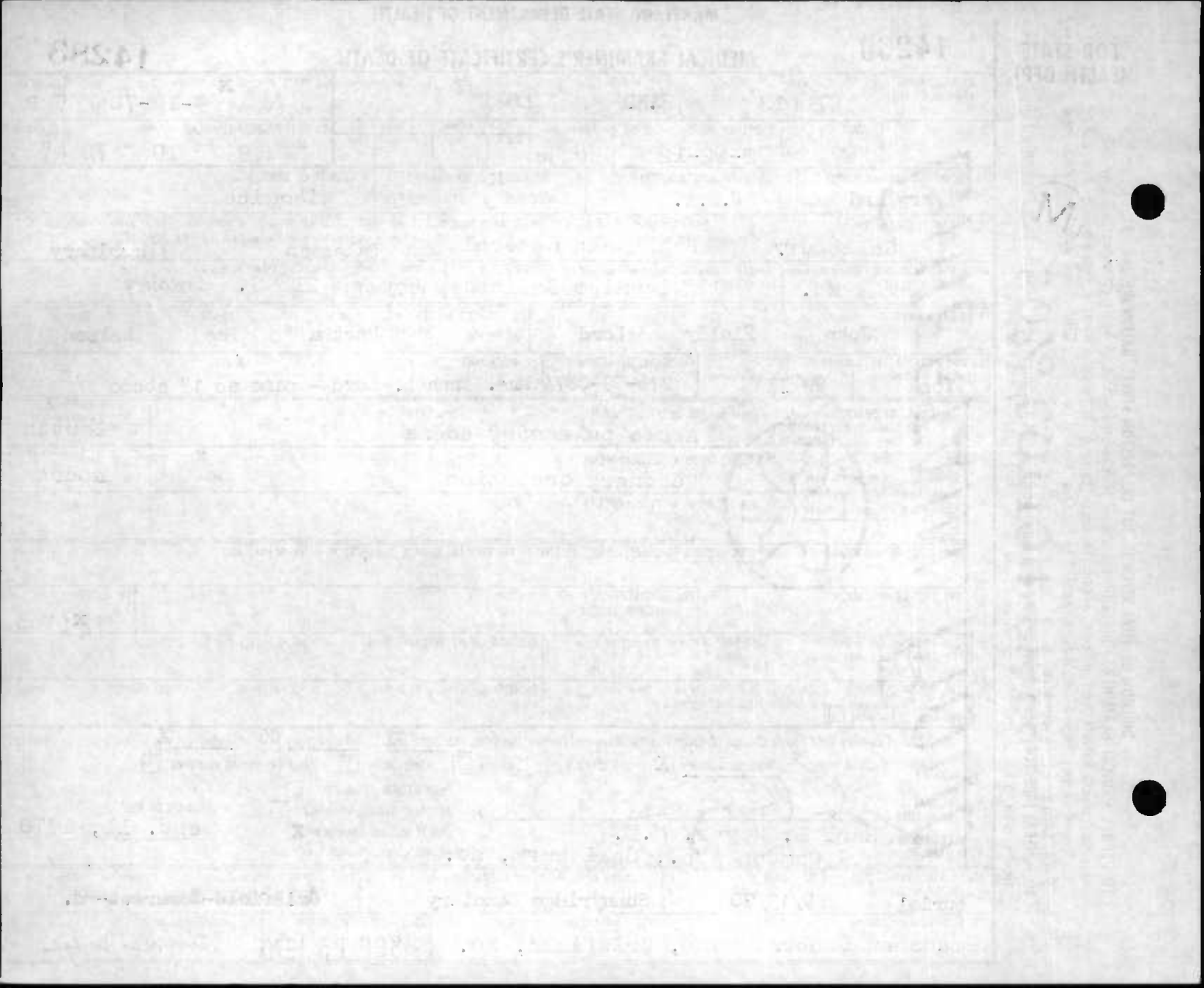
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: Sept. 11, 1970

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| burial | 9/13/70 | Sunnyridge Cemetery | Crisfield-Somerset-Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Bradshaw Funeral Home, Crisfield, Md. | SEP 15 1970 | J. Charles Judge |

VR A15ME (5)
10M - 1/69



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14261 14284

# CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| RUTH | FARRINGTON | MALONE | 9 5 1970 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | Feb. 20, 1898 | 72 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Salisbury Nursing Home | Fed. Employee Retired U.S. Gov't. | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES ☒ NO ☐ | 211 Lee Ave |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| George | | Malone | Vienna | | UNKNOWN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| No | ——— | UNKNOWN | Mr. Russell Malone 613 Smith St. | Salisbury, Maryland |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis
4339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Hypertension arteriosclerosis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 10/10, 1969, to 9/5, 1970, that (I) (we) last saw the deceased alive on 9/5 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Dr. Earl M. Beardsley | | | | | 9/8/70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Dr. Earl M. Beardsley | Civic Ave., Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9-8-1970 | Parsons Cemetery | Salisbury, Wicomico Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Hill Funeral Home Salisbury, Maryland | SEP 9 1970 | J. Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

14262

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14285

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Henry | Middle: - | Last: McDaniel Jr. | 2a. DATE OF DEATH Month Day Year: Sept. 19, 1970 |
| 2b. HOUR: 10:50 p | | | |
| 3. SEX: male | 4. RACE: negro | 5. DATE OF BIRTH: Nov. 12, 1930 | 6. AGE (In years last birthday): 39 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Pine Bluff State Hosp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): laborer | 12b. KIND OF BUSINESS OR INDUSTRY: - |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Dorchester | 13c. CITY OR TOWN: Hurlock | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] |
| 13e. STREET AND NUMBER: - | | | |
| 14. FATHER'S NAME First: Henry | Middle: ~~unknown~~ | Last: McDaniel | 15. MOTHER'S MAIDEN NAME First: Gertrude |
| Middle: - | Last: Conaway | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No | (If yes give war or dates of service): - | 16b. SOCIAL SECURITY NO.: 214-32-1992 | 17. INFORMANT: records of Address: Pine Bluff State Hospital |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO, OR AS A CONSEQUENCE OF

(b): congenital heart disease

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7469

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. I certify that ~~I~~ (this hospital) attended the deceased from Sept. 17, 1970, to Sept. 19, 1970, that ~~I~~ (we) last saw the deceased alive on Sept. 19 1970, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~I~~ (we) (did) (~~did not~~) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: E. P. Ritchings | DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [X] STAFF PHYS. [ ] | 22c. DATE SIGNED: Sept. 20, 1970 | |
| 22d. PHYSICIAN'S NAME (Type): E. P. Ritchings, M.D. | 22e. ADDRESS: Pine Bluff State Hospital | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Sept. 26, 1970 | 23c. NAME OF CEMETERY OR CREMATORY: Washington Cemetery | 23d. LOCATION (City or Town) (County) (State): Hurlock, Dorchester, Md. | |
| 24. FUNERAL DIRECTOR: Framptom / ~~Crowthampton~~ Funeral Home | ADDRESS: Federalsburg, Md. | 25a. REC'D BY REGISTRAR DATE: SEP 29 1970 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | |

VR A15 (4) 45M - 1/69

FOR STATE HEALTH DEPT.

14263

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14286

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form Part 3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: MILTON | Middle: EDWARD | Last: MITCHELL | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] | Month Day Year: 9-29-70 | 2b. HOUR: 12:37 P M | |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH: 8-26-09 | 6. AGE (In years last birthday): 61 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: Month 9 Day 29 Year 1970 | 2d. HOUR: M |
| 7a. BIRTHPLACE (State or foreign country): Md. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Auto mechanic | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE: Del. | 13b. COUNTY: Sussex | 13c. CITY OR TOWN: Delmar | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET AND NUMBER: RD 2 | | | |
| 14. FATHER'S NAME First Middle Last: William Edward Mitchell | 15. MOTHER'S MAIDEN NAME First Middle Last: Bessie Bounds Hearn | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 222-05-7328 | 17. INFORMANT: Lillie Mae Mitchell | ADDRESS: Delmar, Del | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured Abdominal Aortic Aneurysm — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours
4412
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md

22b. DATE SIGNED: Oct. 1, 1970

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 10-2-70 | Odd Fellows Cemetery | Laurel, Sussex, Del. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Marvel Funeral Home, Delmar, Del. | OCT 5 1970 | J. Charles Judge |

VR A15ME (5)
10M - 1/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

14264

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14287

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| RALPH | | MORRIS | September 25 1970 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN. |
|---|---|---|---|---|---|---|---|
| Male | White | October 13, 1898 | 71 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| ,Maryland | USA | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Salisbury Nursing Home | Buyer | Produce |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES ☐ NO ☐ | 510 E. Lincoln Ave. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Eli | P. | Morris | Martha | Florence | Bailey |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (niece) Address |
|---|---|---|
| ~~XXX~~ No | 217-10-2015A | Mrs. Jean Hosier, Salisbury, Maryland 919 Spring Ave. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours.
4339
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Generalized Sclerosis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 9/19, 1920, to 9/25, 1920, that (I) (we) last saw the deceased alive on 9/27 1920 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)(did)~~ (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Earl Beardsley | | ☒ | ☐ | ☐ | September 28/1970 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Dr. E. M. Beardsley | Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 29, 1970 | Wicomico Memorial Park | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | SEP 30 1970 | Charles Judge |

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14265 — 14288

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Ella | Middle: | Last: Parks | 2a. DATE OF DEATH Month: 9 Day: 3 Year: 70 | 2b. HOUR: M |
| 3. SEX: F | 4. RACE: W | 5. DATE OF BIRTH: May 7-1887 | 6. AGE (In years last birthday): 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): MD | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Salisbury Nursing Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired | 12b. KIND OF BUSINESS OR INDUSTRY: Ret. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD | 13b. COUNTY: ~~Somerset~~ | 13c. CITY OR TOWN: Chance | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: Main Rd | |
| 14. FATHER'S NAME First: Archie | Middle: | Last: Jones | 15. MOTHER'S MAIDEN NAME First: Mary | Middle: | Last: Willing |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service): No | 16b. SOCIAL SECURITY NO.: Unknown | 17. INFORMANT: Mrs Myrtle Bitner | Address: 1360 Edgehill Rd Darby, Pa. | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO OR AS A CONSEQUENCE OF (b): Generalized arteriosclerosis — yrs.
DUE TO, OR AS A CONSEQUENCE OF (c):
4339
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from 9/11, 19 69, to 9/3, 19 70, that (I) (we) last saw the deceased alive on 9/2 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 9/4/70

22d. PHYSICIAN'S NAME (Type) — 22e. ADDRESS

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9/6/70 | 23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery | 23d. LOCATION (City or Town): Chance | (County): Som (State): MD |
| 24. FUNERAL DIRECTOR: Leroy Webster | ADDRESS: PRINCESS ANNE MD 21853 | 25a. REC'D BY REGISTRAR DATE: SEP 8 1970 | 25b. REGISTRAR'S SIGNATURE: J Charles Judge | |

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14266 — 14289

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page) 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: ROLAND | Middle: KENNETH | Last: PHIPPIN |
| 2a. DATE OF DEATH | Month: September | Day: 7 | Year: 1970 |
| 2b. HOUR | 5:30 PM | | |
| 3. SEX | Male | | |
| 4. RACE | White | | |
| 5. DATE OF BIRTH | December 15, 1932 | | |
| 6. AGE (In years last birthday) | 37 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country) | Maryland | | |
| 7b. CITIZEN OF WHAT COUNTRY? | USA | | |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | | |
| 9. COUNTY OF DEATH | WICOMICO Md. | | |
| 10. CITY OR TOWN OF DEATH | Salisbury | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | Peninsula General Hospital | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Dental Tech. | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | | |
| 13b. COUNTY | Wicomico | | |
| 13c. CITY OR TOWN | Salisbury | | |
| 13d. INSIDE CITY LIMITS? | YES [X] NO [ ] | | |
| 13e. STREET AND NUMBER | 905 Spring Avenue | | |
| 14. FATHER'S NAME | First: Marion | Middle: Clifford | Last: Phippin |
| 15. MOTHER'S MAIDEN NAME | First: Myrtle | Middle: Emma | Last: Fitzgerald |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | No | | |
| 16b. SOCIAL SECURITY NO. | 220-28-0931 | | |
| 17. INFORMANT (Wife) Address | Mrs. Shirley Faye Phippin, Salisbury, Md. same as 13e | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4123
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Ventricular Aneurysm

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I **certify** that (I) (this hospital) attended the deceased from June, 19 65, to 9/1, 19 70, that (I) (we) last saw the deceased alive on 9/7, 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | David L. Gilmore M.D. | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: September 10 / 1970 |
| 22d. PHYSICIAN'S NAME (Type) | Dr. David Gilmore | 22e. ADDRESS | Salisbury, Maryland |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | Sept. 10, 1970 | Hebron Cemetery | Hebron, Wicomico, Maryland | |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE | |
| HOLLOWAY FUNERAL HOME, | SALISBURY, MARYLAND | SEP 14 1970 | Juanita Judge | |

1
FOR STATE HEALTH DEPT.

Items 18, 21, 22 Film 428

MARYLAND STATE DEPARTMENT OF HEALTH

14267

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14290

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMR Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: ELLEN | Middle: W. | Lost: PREVATT | 2a. DATE KNOWN OF DEATH ESTIMATED ☒ | Month 9 | Day 13 | Year 1970 | 2b. HOUR 12:30 P.M. | | |
| 3. SEX: F | 4. RACE: W | 5. DATE OF BIRTH: 9-28-06 | 6. AGE (In years last birthday): 63 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | 2c. DATE PRONOUNCED DEAD: Month 9 | Day 13 | Year 1970 | 2d. HOUR 1:05 P.M. | |
| 7a. BIRTHPLACE (State or foreign country): Md. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): housewife, own home | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Snow Hill | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: Public Landing | | | | | | |
| 14. FATHER'S NAME: First: Thomas | Middle: Parker | Lost: Wharton | 15. MOTHER'S MAIDEN NAME: First: Mae | Middle: Hubble | Lost: Purnell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (son) ADDRESS: Mr. Nigel MacEwan, New York City, N.Y. | | | | | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Drowning — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

9109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12:30 P.M. 9/13, 1970 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Fell from pier into water |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Own Home | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State: Public Landing, Snow Hill, Wor., Md. |

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: Sept. 14, 1970

| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Sept. 15, 1970 | 23c. NAME OF CEMETERY OR CREMATORY: All Hallows | 23d. LOCATION (City or Town) (County) (State): Snow Hill, Maryland |
|---|---|---|---|
| 24. FUNERAL DIRECTOR ADDRESS: Dennis Funeral Home, Snow Hill, Md. | 25a. REC'D BY REGISTRAR DATE: SEP 17 1970 | 25b. REGISTRAR'S SIGNATURE: J Charles Judge | |

VR A15ME (5)
10M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14268 — 14291

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: MILLARD | Middle: E | Last: PRICE | 2a. DATE OF DEATH Month: SEPTEMBER Day: 7 Year: 1970 | 2b. HOUR: 10 M | |
| 3. SEX: MALE | 4. RACE: White | 5. DATE OF BIRTH: 4-10-1886 | 6. AGE (In years lost birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): MD | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired | 12b. KIND OF BUSINESS OR INDUSTRY: Watchman | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Somerset | 13c. CITY OR TOWN: Chance | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: Main Rd. P.O. Box #60 | | |
| 14. FATHER'S NAME First: Charles | Middle: H. | Last: Price | 15. MOTHER'S MAIDEN NAME First: Julia | Middle: | Last: Jones | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: Unknown | 17. INFORMANT: Dorothy Price - Chance Md | Address: 2/816 | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 da.
4339
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 8-21, 1970, to 9-7, 1970, that (I) (we) last saw the deceased alive on 9-7-70 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Willie A Ellis | | | [X] | [ ] | 9-7-70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 9/10/70 | Rock Creek Cemetery | Chance | Som | Md |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Leroy B. Webster | SEP 14 1970 | J. Charles Judge |

VR A15 (4) 45M - 1/69

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14269 — 14292

1. DECEASED-NAME (Type or print): First RALPH; Middle W.; Last PRICE

2a. DATE OF DEATH: Month September; Day 16; 1970

2b. HOUR: 4:05A M

3. SEX: Male

4. RACE: Negro

5. DATE OF BIRTH: July 10, 1927

6. AGE (In years last birthday): 43 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (State or foreign country): Virginia

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: WICOMICO Md.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Labor

12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland

13b. COUNTY: Wicomico

13c. CITY OR TOWN: Salisbury

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET AND NUMBER: 224 Delaware Avenue

14. FATHER'S NAME: First Unknown; Middle; Last

15. MOTHER'S MAIDEN NAME: First Beatrice; Middle; Last Jones

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Henry Custis 224 Delaware Ave. Salis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ca. of esophagus with metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 mo.

150X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (X) (this hospital) attended the deceased from September 2, 19 70, to September 16, 19 70, that (X) (we) last saw the deceased alive on September 16, 19 70, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (XXXX) view the body after death.

22b. SIGNATURE: W. Maldve, M.D. DEGREE — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. DATE SIGNED: 9/16/70

22d. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22e. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 9/22/ 70

23c. NAME OF CEMETERY OR CREMATORY: Green Acres Cemetary

23d. LOCATION (City or Town) (County) (State): Salisbury Wicomico Md. Md

24. FUNERAL DIRECTOR: Clinton F. Stewart — ADDRESS: Salis. Md

25a. REC'D BY REGISTRAR DATE: SEP 21 1970

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

14270

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14293

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Claudia | Middle: - | Lost: Pritchett | 2a. DATE OF DEATH Month: Sept. Day: 9 Year: 1970 |
| 2b. HOUR: 8:30 P M | | | |
| 3. SEX: female | 4. RACE: white | 5. DATE OF BIRTH: Sept. 29, 1881 | 6. AGE (In years last birthday): 88 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Massachusetts | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Pine Bluff State Hosp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): housewife | 12b. KIND OF BUSINESS OR INDUSTRY: - |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ |
| 13e. STREET AND NUMBER: 1402 N. Salisbury Blv | | | |
| 14. FATHER'S NAME First: George | Middle: - | Lost: Hurtsless | 15. MOTHER'S MAIDEN NAME First: unknown Middle: Lost: |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no | (If yes give war or dates of service): - | 16b. SOCIAL SECURITY NO.: 216-48-5594 | 17. INFORMANT: records of Address: Pine Bluff State Hospital |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if ony, which gave rise to immediote couse (a), stating the underlying couse last. 4124
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. **I certify** that (I) (this hospital) attended the deceased from Aug. 17, 1970, to Sept. 9, 1970, that (I) (we) last saw the deceased alive on Sept. 9 1970 and that in (my) (our) apinian death accurred an the dote and haur and fram the causes stated abave, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: E. P. Ritchings | DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐ | 22c. DATE SIGNED: Sept. 10, 1970 | |
| 22d. PHYSICIAN'S NAME (Type): E. P. Ritchings, M.D. | 22e. ADDRESS: Pine Bluff State Hospital | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9/12/70 | 23c. NAME OF CEMETERY OR CREMATORY: St Stephens | 23d. LOCATION (City or Town) (County) (State): Delmar Sussex Del. |
| 24. FUNERAL DIRECTOR: William Morrod | ADDRESS: Delmar, Del. | 25a. REC'D BY REGISTRAR DATE: SEP 14 1970 | 25b. REGISTRAR'S SIGNATURE: J Charles Judge |

1

**FOR STATE HEALTH DEPT.**

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14271

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14294

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| WALTER | FULTON | PRYOR | 9-14-70 19 | 1 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| M | W | 7-2-25 | 45 YRS. | | | 9 14 19 70 | 11:45 A M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | 713 E. Church St. | NONE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Wicomico | Salisbury | YES ☐ NO ☐ | 713 E. Church St. |

| 14. FATHER'S NAME First Middle Last | 15. MOTHER'S MAIDEN NAME First Middle Last |
|---|---|
| WILLIAM L. PRYOR | MARGARET MAE INGERSOLL |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| YES WAR II | 215-20-0907 | MRS ROBERT PRIER | EASTON, MARYLAND |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Hemorrhagic Pancreatitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5770

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE — M.D.

EXAMINER'S NAME (Type) Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md

22b. **DATE SIGNED** Sept. 14, 1970

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 9/16/1970 | ALLEN CEMETERY | ALLEN, MARYLAND |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Levin Wilson, Princess Anne, Md. | SEP 22 1970 | J. Charles Judge |

VR A15ME (5) 10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

14272 — 14295

1. DECEASED-NAME (Type or print): First HENRY; Middle NATHAN; Last Rayfield
2a. DATE OF DEATH: Month 9 - Day 5 - Year 70
2b. HOUR: 6:45 PM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: May 30, 1899
6. AGE (In years last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Virginia
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Auto Mechanic
12b. KIND OF BUSINESS OR INDUSTRY: General Repair
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Worcester
13c. CITY OR TOWN: Pocomoke
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: R.F.D. 2
14. FATHER'S NAME First Levi; Middle --; Last Rayfield
15. MOTHER'S MAIDEN NAME First Lenora; Middle --; Last Killmon
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
16b. (If yes, give war or dates of service): WW 2
16b. SOCIAL SECURITY NO.: 224-20-0011
17. INFORMANT: William K. Rayfield, Laurel, Delaware — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary oedema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO, OR AS A CONSEQUENCE OF
(b): Pulmonary emphysema
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492 X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 7-22, 19 70, to 9-7, 19 70, that (I) (we) last saw the deceased alive on 9-7 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Wilbur R. Ellis Jr. — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 9-7-70
22d. PHYSICIAN'S NAME (Type): Wilbur R. Ellis, Jr., M.D.
22e. ADDRESS: Medical Center, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9-8-1970
23c. NAME OF CEMETERY OR CREMATORY: Mt. Holly, Ext.
23d. LOCATION (City or Town) (County) (State): Onancock-Accomack-Virginia
24. FUNERAL DIRECTOR: Robert H. Watson — ADDRESS: Pocomoke City, Md.
25a. REC'D BY REGISTRAR DATE: SEP 14 1970
25b. REGISTRAR'S SIGNATURE: Charles Judge

Robert H. Watson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

7 1

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14273

## CERTIFICATE OF DEATH

14296

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First / Middle / Last | GEORGE ROY TAYLOR RAYNE | 2a. DATE OF DEATH Month Day Year | SEPTEMBER 4 1970 |
| 2b. HOUR | 5:53 P.M. | | |
| 3. SEX | Male | 4. RACE | White |
| 5. DATE OF BIRTH | April 15, 1911 | 6. AGE (In years last birthday) | 59 YRS. |
| IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN | |
| 7a. BIRTHPLACE (State or foreign country) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? | USA |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | 9. COUNTY OF DEATH | Wicomico Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | Peninsula General Hospital |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Salesman | 12b. KIND OF BUSINESS OR INDUSTRY | Sundries |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | 13b. COUNTY | Wicomico |
| 13c. CITY OR TOWN | Salisbury | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | |
| 13e. STREET AND NUMBER | 925 Riverside Drive | | |
| 14. FATHER'S NAME First / Middle / Last | Calvin Taylor Rayne | 15. MOTHER'S MAIDEN NAME First / Middle / Last | Lillie Erma Smith |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | No | 16b. SOCIAL SECURITY NO. | 213-10-7543 |
| 17. INFORMANT (Wife) | Mrs. Lillian K. Rayne, Salisbury, Maryland | Address | same as 13e |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Mesenteric Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4442
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitis and Arteriosclerotic Heart Disease & Congest. Failure

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 9-1-70 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | Mesenteric Thrombosis |
| 20a. AUTOPSY? YES [ ] NO [X] | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer) | | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | |
| 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While [ ] at work Not while [ ] at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | |
| 21f. LOCATION Street or R.F.D. No. City or Town County Stote | | | |

22a. I **certify** that (I) ~~(this hospital)~~ attended the deceased from Aug 28, 1970, to Sept 4, 1970, that (I) ~~(we)~~ last saw the deceased alive an Sept 4 1970, and that in (my) ~~(our)~~ opinion death occurred on the date and haur and from the causes stated abave, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Thomas C Hill Jr. M.D. | DEGREE ATTENDING PHYS. [X] ~~MED. DIRECTOR~~ [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED Sept 5, 1970 |
| 22d. PHYSICIAN'S NAME (Type) | Thomas C. Hill, Jr., M.D. | 22e. ADDRESS | Pine Bluff Rd, SALISBURY, Md. |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) (Stote) |
| Burial | Sept. 8, 1970 | Wicomico Memorial Park | Salisbury, Wicomico, Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS | HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | 25a. REC'D BY REGISTRAR DATE | SEP 9 1970 | 25b. REGISTRAR'S SIGNATURE J. Charles Judge |

VR A15 (4) 45M - 1/68

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14274 — Item#7a,b,8,Film G428 9/21/70 — 14297

# CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: HAROLD | Middle: J. | Last: Rayne Sr. | 2a. DATE OF DEATH Month: September | Day: 11 | Year: 1970 | 2b. HOUR: 8:30 AM |
| 3. SEX: male. | 4. RACE: white | 5. DATE OF BIRTH: SEPT 9 1895 | 6. AGE (In years last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY: CANDY CONFECTION | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY OR: OCEAN CITY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 407 EDGEWATER AVE | | | |
| 14. FATHER'S NAME First: JOHN | Middle: J. | Last: RAYNE | 15. MOTHER'S MAIDEN NAME First: SARAH | Middle: | Last: COFFIN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service): No | 16b. SOCIAL SECURITY NO.: 214-32-6752 | 17. INFORMANT: MRS. H.J. RAYNE SR. | Address: OCEAN CITY MD | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Emphysema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While [ ] at work Not while [ ] at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 9-10, 19 70, to 9-11, 19 70, that (I) (we) last saw the deceased alive on 9-11 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| William R Ellis Jr | | [ ] | [ ] | [ ] | 9-11-70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 9/13/70 | SUNSET MEMORIAL | BERLIN WOR MD |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Anna A. Burbage | Berlin Md | SEP 16 1970 | Charles Judge |

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT [illegible]LTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14275 14298

# CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Mary | C. | Reid | 9 - 22 - 70 | 1:25 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | Negro | June 9,1913 | 57 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Alabama | U.S.A | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md | Worcester | Pocomoke,Md | YES ☒ NO ☐ | 513,Laura st.Pocomoke md |

| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last |
|---|---|
| John Mays | Lucy Mobley |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No / No | 218 30 2043 | Willie Campbell,Pocomoke,City,Md. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: weeks
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Pulm. fibrosis — months-yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

517X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Suspected ant Arfutus necro

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |
|---|---|---|
| | | |

22a. I **certify** that (I) (this hospital) attended the deceased from 8/25/70, 19__, to 9/22, 1970, that (I) (we) last saw the deceased alive on 9/22 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Kenneth M. Sims | MD | ☒ | ☐ | ☐ | Sept 22, 1970 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | Salisbury, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 26, 1970 | Halls Hill, Cem | Pocomoke City, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Samuel Lang New Church, Va. | SEP 29 1970 | J. Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14276 — 14299

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: ROY | Middle: S. | Last: ~~REID~~ REID | 2a. DATE OF DEATH: Month September Day 14, Year 1970 | | 2b. HOUR: 5:55PM |
| 3. SEX: Male | 4. RACE: Negro | 5. DATE OF BIRTH: DEC. 14, 1902 | 6. AGE (In years last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: WICOMICO Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): LABORER | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Dorchester | 13c. CITY OR TOWN: Cambridge | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 517 Clinton Street | | |
| 14. FATHER'S NAME First: PETER | Middle | Last: REID | 15. MOTHER'S MAIDEN NAME First: MAGGIE | Middle | Last: BEVINS | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 216-18-2718 | 17. INFORMANT: VIOLA BROMWELL | Address: 517 CLINTON ST. 21613 | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Months

4339

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral vascular insufficiency — Months

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Carcinoma of lung; arteriosclerotic heart disease; pneumonia.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I certify that (I) (this hospital) attended the deceased from January 13, 19 70, to September 14 70, that (I) (we) last saw the deceased alive on September 14, 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: F.J. Murphy Jr. — DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22c. DATE SIGNED: 9/15/70

22d. PHYSICIAN'S NAME (Type): Francis J. Murphy, Jr., M.D. — 22e. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 9/19/70 | 23c. NAME OF CEMETERY OR CREMATORY: WAUGH | 23d. LOCATION (City or Town) (County) (State): CAMBRIDGE DOR. MD. | |
| 24. FUNERAL DIRECTOR: Frederick C. St. Clair | ADDRESS: ST. CLAIR F. HOME CAMBRIDGE, MD. | 25a. REC'D BY REGISTRAR DATE: SEP 21 1970 | 25b. REGISTRAR'S SIGNATURE: J. Charles Judge | |

VR A15 (4) 45M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14277

## CERTIFICATE OF DEATH

15913

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SALISBURY
   c. LENGTH OF STAY IN 1b: ALL LIFE
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
   d. STREET ADDRESS: Jersey Rd. Rt #2
   e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. **NAME OF DECEASED** (Type or print): First JAMES Middle Last Rider

4. **DATE OF DEATH**: Month 9 Day 28 Year 1970

5. SEX: M

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 3-10-14

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): White Haven

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Will Rider

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Benjamin Rider — Address: 414 Patrick Ave.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH: Indefinite

DUE TO (b): Arteriosclerosis — Indefinite

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

4123

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1 Jan., 19 70 to 28 Sept 19 70 that (I) (we) last saw the deceased alive on 28 Sept 19 70, and that death occurred at 12 N from the causes and on the date stated above.

22a. SIGNATURE: E. A. Farnell M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): E. A. Farnell, MD

22d. ADDRESS: 652 W Main; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 10-2-70

23c. NAME OF CEMETERY OR CREMATORY: GREEN ACRES

23d. LOCATION (City, town or county) (State): SALISBURY MD.

24 FUNERAL DIRECTOR'S SIGNATURE: Jolley Memorial Chapel — ADDRESS: SALISBURY, Md.

25a. REC'D BY REGISTRAR DATE: OCT 8 1970

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A1S (4) 20M S-63

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14278 — 14300

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| WILSIE | FLEMING | SEABREASE | September | 15 | 1970 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | July 13, 1907 | 63 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Salisbury Nursing Home | School teacher | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | | Spring Hill Road |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| John | William | Griffin | Edith | Belle | Shockley |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Mother) Address |
|---|---|---|---|
| No | | 219-36-5265 | Box 59 R.D. 5 Spring Hill Rd. Mrs. Edith B. Ross, Salisbury, Maryland |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Uterus & widespread — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1829
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from July 13, 1970, to Sept. 13, 1970, that (I) (we) last saw the deceased alive on Sept 13, 1970, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED September 19/1970

22d. PHYSICIAN'S NAME (Type) Dr. E. M. Beardsley — 22e. ADDRESS Salisbury, Maryland

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 17, 1970 | Springhill Memory Gardens | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | SEP 21 1970 | J. Charles Judge |

VR A15 (4)
30M REV. 1/68

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14279 — 14301

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First / Middle / Last | Lottie C. Shockley | 2a. DATE OF DEATH Month / Day / Year | September 30 1970 | 2b. HOUR | 4:45 PM |
| 3. SEX | Female | 4. RACE | White | 5. DATE OF BIRTH | Feb. 9 1882 |
| 6. AGE (In years last birthday) | 88 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | |
| 9. COUNTY OF DEATH | Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Housewife |
| 12b. KIND OF BUSINESS OR INDUSTRY | Own Home | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | 13b. COUNTY | Worcester | 13c. CITY OR TOWN | Snow Hill |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☑ | | 13e. STREET AND NUMBER | | | |
| 14. FATHER'S NAME First / Middle / Last | Elijah A. Carmean | 15. MOTHER'S MAIDEN NAME First / Middle / Last | Maria Parsons | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | No | 16b. SOCIAL SECURITY NO. | Unknown | 17. INFORMANT Address | Mrs. Virginia S. Clayville, Snow Hill Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9 23 70
DUE TO, OR AS A CONSEQUENCE OF (b) ASCV Disease — Not Known
DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): G.I Tract Bleeding of unknown origin; Diabetes Mellitus

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from 9/15/70, 19 to 9/30/70, 19, that (I) (we) last saw the deceased alive on 9/30/70 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | Oct 3 1970 | Bates Methodist | Snow Hill | Maryland |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE | |
| Truman F. Ellis, | Snow Hill, Md. | OCT 5 1970 | Charles Judge | |

VR A15 (4) 45M - 1/69

1

**FOR STATE HEALTH DEPT.**

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form VM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14280

14302

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| MARTIN | STEVEN | SHORES | 9-22-70 | 12:35 P |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| M | W | 3-21-52 | 18 YRS. | | | 9 22 1970 | M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | Single | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General | Service station | serv. stat. |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Somerset | Wenona | YES ☒ NO ☐ | Box 47 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Martin | E | Shores | Edwina | W | Shores |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | Unknown | Martin Shores | Wenona Md. 21870 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Fractured skull — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

8120

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | 11:45 9-21-70 | Driver of auto, ran into back of truck |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | highway | Route 13, Princess Anne, Somerset, Md |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Earl L. Royer M.D.

EXAMINER'S NAME (Type) Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. **DATE SIGNED** Sept. 22, 1970

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/25/70 | St Paul's Cemetery | WENONA SOM MD |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Leroy Webster Webster Funeral Home, Princess Anne, Md | Deal Island Rd. | SEP 28 1970 | J. Charles Judge |

VR A15ME (5) 10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

14281

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14303

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Lawrence | | Sinagra | 9-8-70 19 | 5:20 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| M | W | 1/26/33 | 37 YRS. | | | | | 9 8 19 70 | M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| New York City | US | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General | Retired | AIR FORCE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Wicomico | Delmar | YES [X] NO [ ] | 106 State St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Joseph | | Sinagra | Frances | | Greco |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| yes | | Frances Sinagra | Delmar Md |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bullet wound of brain — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 955X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Acute depression.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [ ] NO [X] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | 5:05 AM 9-8-70 | Self-inflicted. |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | own Home | 106 State St., Delmar, Wicomico, Md. |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [X] Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type) Earl L. Royer, M.D. ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.

22b. DATE SIGNED Sept. 10, 1970

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/10/70 | St Stephens | Delmar Sussex Co. Del. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Marvel Funeral Home, Delmar, Del. | SEP 14 1970 | J. Charles Jones |

VR A15ME (5) 10M - 1/69

14282

Item#23a,b,c,d,FilmG429 10/2/70 k

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14304

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Neal | - | Spence | Sept. 18, 1970 | 3:30 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| male | negro | March 3, 1883 | 87 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Pine Bluff State Hosp. | farmer | - |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Somerset | Eden | | Box 29 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Billy | - | Spence | Mary | - | Spence |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| No | - | 144-04-3491 | records of | Pine Bluff State Hospital |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (☒ (this hospital) attended the deceased from Sept. 11, 19 70, to Sept 18, 19 70, that ☒ (we) last saw the deceased alive an Sept. 18 19 70, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, ☒ (we) (did) ~~(did not)~~ view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☐ | MED. DIRECTOR ☒ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| E P Ritchings | | | | | Sept. 18, 1970 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| E. P. Ritchings, M.D. | Pine Bluff State Hospital |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/21/70 | Eden Church Cem. | Eden, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Baker McLeod | | SEP 24 1970 | J Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

1
FOR STATE HEALTH DEPT.

14283 Item#2a,b,FilmG429 10/2/70 km

# MARYLAND STATE DEPARTMENT OF HEALTH
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14305

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: JOHN | Middle: NEAVITT | Last: STAFFORD | 2a. DATE KNOWN OF DEATH ESTIMATED ☒ | Month: Sept. | Day: 15 | Year: 1970 | 2b. HOUR: 1 A M | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: Jan. 31, 1919 | 6. AGE (In years last birthday): 51 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: Month: September | Day: 15 | Year: 1970 | 2d. HOUR: M | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. COUNTY OF DEATH: WICOMICO Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 214 Linwood Avenue | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Machine Operator | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 214 Linwood Avenue | | | | | | |
| 14. FATHER'S NAME First: Neavitt | Middle | Last: Stafford | 15. MOTHER'S MAIDEN NAME First: Beatrice | Middle: Jane | Last: McHugh | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWII & Korean | 16b. SOCIAL SECURITY NO.: 214-10-9786 | 17. INFORMANT (Mother) ADDRESS same as 13e: Mrs. Beatrice J. Stafford, Salisbury, Maryland | | | | | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. 4270

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M. D.

ADDRESS(Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: September 15 /1970

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (Counly) (Stote) |
|---|---|---|---|
| Burial | Sept. 17, 1970 | Parsons Cemetery | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | SEP 21 1970 | J. Charles Judge |

VR A15ME (5) 10M - 1/69

1

14284

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14306

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | RUBY | Middle ---- | Lost STANBAUGH |
| 2o. DATE OF DEATH Month Day Year | September 11 1970 | 2b. HOUR | 11 AM |
| 3. SEX | Female | | |
| 4. RACE | White | | |
| 5. DATE OF BIRTH | June 16, 1893 | | |
| 6. AGE (In yeors lost birthday) YRS. | 77 | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 7o. BIRTHPLACE (Stote or foreign country) | Maryland | | |
| 7b. CITIZEN OF WHAT COUNTRY? | USA | | |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | | |
| 9. COUNTY OF DEATH | WICOMICO Md. | | |
| 10. CITY OR TOWN OF DEATH | Salisbury | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | Springhill Nursing Home | | |
| 12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Housewife | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | ---- | | |
| 13o. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE | Maryland | | |
| 13b. COUNTY | Wicomico | | |
| 13c. CITY OR TOWN | Salisbury | | |
| 13d. INSIDE CITY LIMITS? | YES ☐ NO ☐ | | |
| 13e. STREET AND NUMBER | South Blvd. | | |
| 14. FATHER'S NAME First | Jobe | Middle | Hastings |
| 15. MOTHER'S MAIDEN NAME First | Lavenia | Middle | Massey |
| 16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | no | (If yes give war or dates of service) | |
| 16b. SOCIAL SECURITY NO. | 212-56-1668 | | |
| 17. INFORMANT | (Brother-in-law) Mr. Oscar F. Smith, Salisbury, Maryland | Address | 414 Hammond St. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o) Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10'

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying cause lost. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

| | | | |
|---|---|---|---|
| 19o. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20o. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote | |

22a. **I certify** that (I) (this hospital) attended the deceased from June, 1970, to 9/11, 1970, that (I) (we) last saw the deceased alive on 9/9 1970, and that in (my) (our) opinian death occurred on the date and haur and from the causes stated abave. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Frank L. Weaver M.D. | DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED September 12, 1970 |
| 22d. PHYSICIAN'S NAME (Type) | Frank L. Weaver, M.D. | 22e. ADDRESS | Salisbury, Maryland |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (Stote) | |
| Burial | Sept. 14, 1970 | Hastings Family Cemetery | Salisbury, Wicomico, Maryland | |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE | |
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | | SEP 16 1970 | J. Charles Judge | |

VR A15 (4)
30M REV. 1/68

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14285 — 14307

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year / 2b. HOUR |
| VALLEY | (Arthur) | STANLEY | September | 7 | 1970 / M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| Male | White | February 9, 1898 | 72 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH | | |
| Pennsylvania | USA | | WICOMICO | | Md. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Salisbury | Salisbury Nursing Home | Salesman | Furniture | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER | |
| Maryland | Wicomico | Salisbury | | R.D. 4, Snow Hill Road | |
| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
| James | | Stanley | Rhodey | | Smith |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Son) | Address same as 13e | | |
| No | 219-16-2810 | Mr. Jack V. Stanley, Salisbury, Maryland | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Thrombosis — 1 month

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

4339 Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 6/19, 1920, to 9/7, 1970, that (I) (we) last saw the deceased alive on 9/6 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE E. M. Beardsley — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED September 8 /197

22d. PHYSICIAN'S NAME (Type) Dr. E. M. Beardsley — 22e. ADDRESS Salisbury, Maryland

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (Stote) |
|---|---|---|---|
| Burial | Sept. 10, 1970 | Wicomico Memorial Park | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | SEP 14 1970 | J. Charles Judge |

VR A15 (4) 30M REV. 1/68

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14286

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14308

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Helen | J. | Stokes | September | 13 | 1970 | 6:55 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) YRS. | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Female | Negro | 6- 1900 | 70 | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Somerset Co | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Deer's Head State Hospital | Domestic | none |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Somerset | Dames Quarter | | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Henry A. | | Jones | Minnie | | Roberts |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes, give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| No. | 217-30-8472 | Carl Stokes | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Recurrent Cerebral Thrombosis

DUE TO, OR AS A CONSEQUENCE OF

(b) Hypertensive Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4132

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Obesity

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from September 29 70, to September 13, 1970 That (I) (we) last saw the deceased alive, September 13 19 70, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| W. Maldve (?) | | ☐ | ☐ | ☒ | 9/13/70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| L.V. Maldve, M.D. | Deer's Head State Hospital, Salisbury Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9-16-70 | Mt Calvary Cem | Fruitland Wico. Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Baker M. West. | | SEP 18 1970 | J. Charles Judge |

VR A15 (4) 45M - 1/69

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**FOR STATE HEALTH DEPT.**

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form MA-3. Page 3 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH

14287

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14309

| 1. DECEASED-NAME (Type or Print) First | Middle | Last |
|---|---|---|
| ROBERT | NORMAN RAY | TAYLOR |

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month 9 Day 8 Year 19 70 — 2b. HOUR 5:40 P.M.

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Male | White | Sept. 8, 1970 | 0 YRS. | | | | 3 |

2c. DATE PRONOUNCED DEAD: Month September Day 8 Year 19 70 — 2d. HOUR M.

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | Baby | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | none | --- |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES [ ] NO [ ] | Rt. 1, Siloam, Box 150 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| John | Emory | Taylor | Patricia | Lee | Burke |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Father) ADDRESS same as 13e |
|---|---|---|
| no | | Mr. John Emory Taylor, Salisbury, Maryland |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Prematurity — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

777X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer, M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: September 10/1970

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | Sept. 11, 1970 | Riverside Cemetery | Libertytown | | Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | SEP 14 1970 | J. Charles Judge |

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14288 — 14310

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper(s). Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: ELSIE | Middle: ANNA | Last: TRAPKIN | 2a. DATE OF DEATH Month: SEPTEMBER Day: 24 Year: 1970 | 2b. HOUR: 2:36 P.M. |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: 10-12-1907 | 6. AGE (In years last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): N. J | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): House Wife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: WICOMICO | 13c. CITY OR TOWN: SALISBURY | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: 110 DIAMOND Ave | |
| 14. FATHER'S NAME First: FERDINAND | Middle: | Last: KADEL | 15. MOTHER'S MAIDEN NAME First: ANNA | Middle: | Last: BRAMBLE |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 149-38-0207 | 17. INFORMANT: JAMES TRAPKIN | Address: See Sec 13 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Amyotrophic Lateral Sclerosis — 3480
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☑ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from Sept 23, 1970, to Sept 24, 1970, that (I) (~~me~~) last saw the deceased alive on Sept 24 1970, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~me~~) (did) (~~did not~~) view the body after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE: Thomas C Hill MD | DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED: Sept 24, 1970 |
| 22d. PHYSICIAN'S NAME (Type): Thomas C. Hill Jr | 22e. ADDRESS: Pine Bluff Road Salisbury, Md | | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION | 23b. DATE: 9/25/1970 | 23c. NAME OF CEMETERY OR CREMATORY: J. Wm. Lee Crematory | 23d. LOCATION (City or Town): Washington | (County) D.C. (State) |
| 24. FUNERAL DIRECTOR: Hill Funeral Home | ADDRESS: Salisbury, Md | 25a. RECD BY REGISTRAR DATE: SEP 28 1970 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | |

VR A15 (4)
45M - 1/69

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14289
Item#13, Film G429 10/5/70 km

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14311

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely (filled in) by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| BABY | BOY | TRUITT | SEPTEMBER | 27 | 1970 | 1 35 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| MALE | WHITE | SEPT. 26 1970 | YRS. | | | 15 | 41 |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| WICOMICO Md. | USA. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Worcester | Berlin | | RFD |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WAYNE | E. | TROITT | DELLA | ANN | BOZMAN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| | | Wayne E. Truitt | Berlin, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Distress Syndrome
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
7762
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 min / 60

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 5/26/70, 19___, to 9/27/70, 19___, that (I) (we) last saw the deceased alive on 9/27/70 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Chester C Collier MD | | ☒ | ☐ | ☐ | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/28/70 | Riverside | Berlin Worcester Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Peter W Haley | Selbyville Del. | SEP 30 1970 | Charles Judge |

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14230 — 14312

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: MARGARET | Middle: MARY | Last: TRUITT | 2a. DATE OF DEATH Month: September | Day: 26 | Year: 1970 |
| 2b. HOUR | 1:15 PM | | | | | |
| 3. SEX | Female | | | | | |
| 4. RACE | White | | | | | |
| 5. DATE OF BIRTH | April 28, 1900 | | | | | |
| 6. AGE (In years last birthday) | 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | Pennsylvania | | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | USA | | | | | |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | | | | | |
| 9. COUNTY OF DEATH | WICOMICO Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | Salisbury | | | | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | Peninsula General Hospital | | | | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Housewife | | | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | --- | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | | | | | |
| 13b. COUNTY | Worcester | | | | | |
| 13c. CITY OR TOWN | Ocean City | | | | | |
| 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | | | | | | |
| 13e. STREET AND NUMBER | 74th Street | | | | | |
| 14. FATHER'S NAME First | Jacob | Middle | Atchison | Last | | |
| 15. MOTHER'S MAIDEN NAME First | Matilda | Middle | Fulton | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | No | | | | | |
| 16b. SOCIAL SECURITY NO. | | | | | | |
| 17. INFORMANT (Husband) Address | Mr. Gerald B. Truitt, Sr., same as 13e Ocean City, Md. | | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral encephalomalacia — Approximate Interval Between Onset and Death: Not Known

DUE TO, OR AS A CONSEQUENCE OF (b) Multiple CVA.

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4369

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Intestinal hemorrhage Cerebral edema

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [X] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | | |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote |

22a. **I certify** that (I) (this hospitol) attended the deceased from 9/14, 19 70 to 9/26, 19 70, that (I) (we) last saw the deceased alive on 9/26, 19 70, and that in (my) (our) opinian death occurred on the date and hour and from the causes stated obave, (I) (we) (did) (did not) view the body after deoth.

22b. SIGNATURE — DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: September ___/1970

22d. PHYSICIAN'S NAME (Type): Dr. O. J. Burton

22e. ADDRESS: Salisbury, Maryland

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (Stote) | |
| Burial | Sept. 29, 1970 | Parsons Cemetery | Salisbury, Wicomico, Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS | HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | 25a. REC'D BY REGISTRAR DATE | SEP 30 1970 | 25b. REGISTRAR'S SIGNATURE J. Charles Judge |

VR A15 (4) 30M REV. 1/68

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14291

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14313

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Missouri (Missouri) | Middle: Ellen (Missouri) | Last: Twilley | 2a. DATE OF DEATH Month: Sept. Day: 7 Year: 1970 | 2b. HOUR: M |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: Dec. 7, 1882 | 6. AGE (In years last birthday): 87 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico | Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Salisbury Nursing Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Pittsville | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: RFD |
| 14. FATHER'S NAME First: Joseph | Middle: Baker | Last: | 15. MOTHER'S MAIDEN NAME First: Naomi | Middle: Baker Last: |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): xx | (If yes give war or dates of service): xx | 16b. SOCIAL SECURITY NO.: xxx | 17. INFORMANT: Cloyde Twilley | Address: Pittsville, Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic heart disease — yrs.

DUE TO, OR AS A CONSEQUENCE OF (c):

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from 8/31, 1970, to 9/7, 1970, that (I) (~~we~~) last saw the deceased alive on 9/6 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Earl M. Beardsley — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 9/18/70.

22d. PHYSICIAN'S NAME (Type): Earl M. Beardsley — 22e. ADDRESS: U.S. 50 at Civic Avenue

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9/10/70 | 23c. NAME OF CEMETERY OR CREMATORY: Bethel | 23d. LOCATION (City or Town): Willards | (County): Wicomico (State): Md. |
| 24. FUNERAL DIRECTOR: Peter Whaley | ADDRESS: Selbyville, Del. | 25a. REC'D BY REGISTRAR DATE: SEP 23 1970 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | |

VR A15 (4)
45M - 1/69

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# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14292

14314

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: IDA | Middle: SHAW | Last: Vincent | 2a. DATE OF DEATH Month: 9 Day: 5 Year: 70 |
| 2b. HOUR: 24 M | | | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: Dec. 28, 1901 | 6. AGE (In years last birthday): 68 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: -- |
| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Pocomoke | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] |
| 13e. STREET AND NUMBER: 15 Clarke Avenue | | | |
| 14. FATHER'S NAME First: Daniel | Middle: W. | Last: Shaw | 15. MOTHER'S MAIDEN NAME First: Louise | Middle: -- | Last: Hearn |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no (If yes give wor or dates of service): -- | 16b. SOCIAL SECURITY NO.: 213-42-0842 | 17. INFORMANT Address: Paul R. Vincent, Pocomoke City, Md. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 da
4339
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended ~~the~~ deceased from 9-3, 19 70, to 9-5, 19 70, that (I) (we) last saw the deceased alive an 9-5 19 70 and that in (my) (aur) apinion death accurred on the date and haur ond from the causes stated abave, (I) (we) (did) (did nat) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Wilbur R. Ellis | DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 9-5-70 | |
| 22d. PHYSICIAN'S NAME (Type): Wilbur R. Ellis, M.D. | 22e. ADDRESS: Medical Center, Salisbury, Md. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9-7-1970 | 23c. NAME OF CEMETERY OR CREMATORY: Salem Methodist | 23d. LOCATION (City or Town) (County) (State): Pocomoke City-Wor.-Md. | |
| 24. FUNERAL DIRECTOR: Robert H. Watson | ADDRESS: Pocomoke City, Md. | 25a. REC'D BY REGISTRAR DATE: SEP 8 1970 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | |

Robert H. Watson

VR A15 M
45M - 1/69

1

14293

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14315

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/89

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: GEORGE | Middle: T. | Last: WAINWRIGHT | 2a. DATE OF DEATH: Month September Day 24 Year 1970 — 2b. HOUR: 8:00A M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: DEC 24, 1875 | 6. AGE (In years last birthday): 94 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: WICOMICO Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Berlin | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: Rt. #3 |
| 14. FATHER'S NAME First: EBENEZER | Middle: W | Last: WAINRIGHT | 15. MOTHER'S MAIDEN NAME First: ADA ESTELLE | Middle: M | Last: MITCHELL |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service): No | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address: MR. RUSSELL WAINRIGHT BERLIN MD | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days
485X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Generalized arteriosclerosis

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (X) (this hospital) attended the deceased from September 21, 19 70, to September 24, 19 70, that (I) (we) last saw the deceased alive on September 24, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Francis J. Murphy, Jr. — DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22c. DATE SIGNED: 9/24/70

22d. PHYSICIAN'S NAME (Type): Francis J. Murphy, Jr., M.D. — 22e. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 9/27/70 | 23c. NAME OF CEMETERY OR CREMATORY: TAYLORVILLE | 23d. LOCATION (City or Town): BERLIN | (County): WOR | (State): MD |
| 24. FUNERAL DIRECTOR: Anna A. Bunbage | ADDRESS: Berlin MD | 25a. REC'D BY REGISTRAR DATE: SEP 28 1970 | 25b. REGISTRAR'S SIGNATURE: J. Charles Judge | | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

14294 — 14316

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Henry | Middle: James | Last: Whayland | 2a. DATE OF DEATH Month: September | Day: 26 | Year: 1970 |
| 2b. HOUR | 4:15 A M | | | | | |
| 3. SEX | Male | | | | | |
| 4. RACE | White | | | | | |
| 5. DATE OF BIRTH | October 18, 1888 | | | | | |
| 6. AGE (In years last birthday) | 81 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) | Maryland | | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | USA | | | | | |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | | | | | |
| 9. COUNTY OF DEATH | Wicomico Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | Salisbury | | | | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Deer's Head State Hospital | | | | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Produce Manager | | | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | Super Market | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | | | | | |
| 13b. COUNTY | Wicomico | | | | | |
| 13c. CITY OR TOWN | Salisbury | | | | | |
| 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | | | | | | |
| 13e. STREET AND NUMBER | 110 Tilghman Street Allen Drive, Rt. #6 | | | | | |
| 14. FATHER'S NAME First | Charles | Middle: Lorne | Last: Whayland | | | |
| 15. MOTHER'S MAIDEN NAME First | Sarah | Middle: Pricilla | Last: Brombley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | Yes Co. I, National Guard | | | | | |
| 16b. SOCIAL SECURITY NO. | 217-10-3777 | | | | | |
| 17. INFORMANT | (Son) R.D. 6 Address Allen Drive<br>Mr. George H. Whayland, Salisbury, Maryland | | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Penis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic Pulmonary Emphysema

| | | | | |
|---|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. I **certify** that (I) (this hospital) attended the deceased from May 4, 1970, to September 26 70 that (I) (we) last saw the deceased olive on September 26, 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles H. Winnacott M.D. — DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22c. DATE SIGNED: September 26, 1970
22d. PHYSICIAN'S NAME (Type): Charles H. Winnacott, M.D.
22e. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | Sept. 29, 1970 | Parsons Cemetery | Salisbury, Wicomico, Maryland | |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE | |
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | | SEP 30 1970 | J. Charles Judge | |

VR A15 (4) 45M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14295 — 14317

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: AVIS | Middle: | Last: WHEATLEY | 2a. DATE OF DEATH Month: September Day: 9, Year: 1970 |
| 2b. HOUR: 2:45 P M | | | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: Mar. 26, 1890 | 6. AGE (In years last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Kent Co. Md. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐ | 9. COUNTY OF DEATH: WICOMICO Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Deer's Head State Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Kent | 13c. CITY OR TOWN: Chestertown | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ |
| 13e. STREET AND NUMBER: 1125 Mill Street | | | |
| 14. FATHER'S NAME First: Thomas | Middle: S. | Last: Dodd | 15. MOTHER'S MAIDEN NAME First: Mary Middle: Howard Last: |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Chas. Wheatley, Jr. | Address: Betterton, Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral thrombosis — 6 months

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4339

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes mellitus

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote | |

22a. I certify thot I (this hospitol) attended the deceased from May 13, 19 70, to September 9 1970, thot I saw the deceased alive on September 9, 19 70 and thot in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE: W. Wheatley M.D. — DEGREE — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22c. DATE SIGNED: 9/9/70

22d. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D. — 22e. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9/12/70 | 23c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery | 23d. LOCATION (City or Town) (County) (State): Chestertown, Md. | |
| 24. FUNERAL DIRECTOR: William Wells | ADDRESS: Chestertown, Md. | 25a. REC'D BY REGISTRAR DATE: SEP 14 1970 | 25b. REGISTRAR'S SIGNATURE: J. Charles Judge | |

VR A15 (4) 45M - 1/69

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14296 — 14318

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Mary | A. (Crawford) | Widgeon | Sept. 27, 1970 | 5:50 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | 2-7-1884 | 86 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Virginia | U.S. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Springhill Nursing Home | Retired School Teacher | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | | 710 Parkway Circle |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Julius | Clairbourne | Arnett | Rode | Yancey | Crawford |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give wor or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Daughter) Address same as 13e |
|---|---|---|
| No | | Mrs. Franky Fries, Salisbury, Maryland |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 4369 | IMMEDIATE CAUSE (a) Cerebro Vascular accident | days |
| | DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Brain Syndrom | yrs |
| | DUE TO, OR AS A CONSEQUENCE OF (c) | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port I or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this haspital) attended the deceased from _____, 19____, ta _____, 19____, that (I) (we) last saw the deceased alive an _____ 19____, and that in (my) (our) apinion death occurred on the date and hour and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☐ | MED. DIRECTDR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Andrew C. Mitchell | | | | | 9/28/70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Andrew C. Mitchell, M.D. | Fruitland, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 30, 1970 | Parsons Cemetery | Salisbury, Wicomico, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Holloway Funeral Home, Salisbury, Md. | OCT 2 1970 | J. Charles Judge |

VR A15 (1)
45M - 1 '69

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14297

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #13 taken from birth cert. **CERTIFICATE OF DEATH** 9/14/70 pcs

14319

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month - Day - Year | 2b. HOUR |
|---|---|---|---|---|
| Harim | Orlando | Wiles | 9 - 4 - 70 | 6-35 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| male | white | Sept. 30, 1970 | — YRS. | X | 1 | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Md. | U.S. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Somerset | Eden | YES ☐ NO ☐ | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Paul D. | | Wiles | Linda | | Moorefield |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | | Paul Wiles, Eden, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Distress Syndrome
DUE TO, OR AS A CONSEQUENCE OF
(b) Immaturity 3# 13 oz
DUE TO, OR AS A CONSEQUENCE OF
(c)

7762
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** thot (I) (this hospital) attended the deceased from 9/3, 1970, to 9/4, 1970, thot (I) (we) lost sow the deceased olive on 9/4 1970 ond that in (my) (our) opinion deoth occurred on the date ond hour ond from the couses stoted obove, (I) (we) (did) (did not) view the body ofter death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| William C. Morgan | | ☒ | ☐ | ☐ | 9/4/70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| William C. Morgan | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/6/70 | Beechwood | Princess Anne; Somerset, Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| James L. Herman | Princess Anne, Md. | SEP 14 1970 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

14298

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14320

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: William Broughton | Middle: | Last: Woolford, Sr. | 2a. DATE OF DEATH Month: September | Day: 16 | Year: 1970 |
| 2b. HOUR: 9P M | | | | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: April 21, 1899 | 6. AGE (In years last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): General Store | 12b. KIND OF BUSINESS OR INDUSTRY: Owner | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Quantico | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: Rt #1 | |
| 14. FATHER'S NAME First: George | Middle: A. | Last: Woolford | 15. MOTHER'S MAIDEN NAME First: Martha | Middle: E. | Last: Dosiee |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Mrs. Ruth T. Woolford | Address: See Sec 13 | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7d 0

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that (I) (this hospital) attended the deceased from 9-10, 19 70, to 9-17, 19 70 that (I) (we) last saw the deceased alive on 9-17 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Wilbur R. Ellis | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 9-17-1970 | |
| 22d. PHYSICIAN'S NAME (Type): Wilber R. Ellis, Jr., M.D. | 22e. ADDRESS: Salisbury, Maryland. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9-19-1970 | 23c. NAME OF CEMETERY OR CREMATORY: St. Philips Ch. Yard | 23d. LOCATION (City or Town) (County) (State): Quantico Wicomico Md. | |
| 24. FUNERAL DIRECTOR: Hill Funeral Home | ADDRESS: Salisbury, Md. | 25a. REC'D BY REGISTRAR DATE: SEP 21 1970 | 25b. REGISTRAR'S SIGNATURE: J. Charles Judge | |

VR A15 (4)
45M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14299

## CERTIFICATE OF DEATH

14321

1. DECEASED-NAME (Type or print): First: Walter; Middle: ; Last: Wright

2a. DATE OF DEATH: Month: September; Day: 3; Year: 1970

2b. HOUR: 8:49 P.M.

3. SEX: Male

4. RACE: Col.

5. DATE OF BIRTH: June 5, 1912

6. AGE (In years lost birthday): 58 YRS.

IF UNDER 1 YEAR: MONTHS: ; DAYS: ; IF UNDER 24 HRS.: HOURS: ; MIN.:

7a. BIRTHPLACE (State or foreign country): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Wicomico Md.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Labor

12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland

13b. COUNTY: Wicomico

13c. CITY OR TOWN:

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 110 Second St.

14. FATHER'S NAME First: John; Middle: ; Last: Curtis

15. MOTHER'S MAIDEN NAME First: Della; Middle: ; Last: Wright

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service):

16b. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Laura Wright 110 First St. Salis- Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARCINOMA LUNG — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 8/28/70

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: 18-(a)

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (~~this hospital~~) attended the deceased from 8/10, 1970, to 9/2, 1970, that (I) (~~we~~) last saw the deceased alive on 9/2 19 70, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: John W. Bloxom III MD — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 9/3/1970

22d. PHYSICIAN'S NAME (Type): J. M. Bloxom III

22e. ADDRESS: MEDICAL CENTER, SALISBURY, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 9/7/70

23c. NAME OF CEMETERY OR CREMATORY: Green Acress

23d. LOCATION (City or Town) (County) (State): Salisbury Wicomico Md.

24. FUNERAL DIRECTOR: Clinton F. Stewart

ADDRESS: Salis Md.

25a. REC'D BY REGISTRAR DATE: SEP 9 1970

25b. REGISTRAR'S SIGNATURE: Charles Judge

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4
45M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

14300

14322

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| GEORGE | WILLIAM | YOUNGER | September | 6 | 1970 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | Feb. 7, 1899 | 71 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| North Carolina | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Salisbury Nursing Home | Manufacture Representative | Tobacca |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES [ ] NO [ ] | 107 W. Union Ave. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Richard | | Younger | Pamela | Jane | Caudle |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Wife) Address |
|---|---|---|
| No | 243-10-0154 | Mrs. Eva M. Younger, Salisbury, Maryland same as 13e |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 month

4339

Conditians, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 9/24, 1970 to 9/8, 1970, that (I) (we) last saw the deceased alive on 9/24 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(we)~~ (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Dr. E. M. Beardsley | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | Sept. 8 /1970 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Dr. E. M. Beardsley | Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 9, 1970 | Parsons Cemetery | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | SEP 14 1970 | J. Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV. 1/68